CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if availoble	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD. (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber M.D. Title: Commissioner of Health — 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	[X]	[ ]

REMARKS: 2 negative Rolls

C P Force — Records Management Officer — 3/29/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—1-10-21 – M&T – 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24076

CERTIFICATE OF DEATH.

138 E 24076

REGISTERED NO.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Gertrude O'Brien

(a) RESIDENCE No. 1422 N Bethel St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William W. O'Brien

6 DATE OF BIRTH (month, day, and year) Oct. 1887

7 AGE 39. Years 9. Months Days If LESS than 1 day, hrs. or min. 1/0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Charles Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER Emma V. Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant William W. O'Brien

(Address) 1422 N. Bethel St

15 Filed JUL 19 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17 – 1927.

17 I HEREBY CERTIFY, That I attended deceased from 7-12, 1927. to 7-17, 1927.

that I last saw her alive on 7-17, 1927.

and that death occurred, on the date stated above, at 5 10 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Salpingitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? Yes Date of 7-13-27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) William Wilson, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County. DATE OF BURIAL July 20 1927

20 UNDERTAKER George F. Rutter ADDRESS 1735 Harford Ave

C. HAMPSON JONES, M. D.

Notice stating by whom certificate supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

Buenger.

E 24077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 24077

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 N. Spring ST., 9th WARD)

2-FULL NAME Christina Buenger

(a) RESIDENCE NO. 1618 N. Spring ST., 9th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Buenger

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE 76 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Valentine Vosnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Mitchell

(Address) 1618 N. Spring St.

15 Filed JUL 18 1927, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1927

17 I HEREBY CERTIFY, That I attended deceased from ~~April~~ July 16, 1927, to July 18, 1927, that I last saw her alive on July 18, 1927, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) — yrs. — mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Tenby M. D.

7/19, 1927 (Address) 1118 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL 7/21 1927

20 UNDERTAKER: George J Ruth — ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Karoly Barsos

HEALTH DEPARTMENT—CITY OF BALTIMORE

24078

CERTIFICATE OF DEATH.

E 24078

1-PLACE OF DEATH

City of BALTIMORE: (No.) City Hospital St. Ward) 37

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Karoly Barsos

(a) RESIDENCE NO. Sparrows Point St. Ward Gen Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Ester Barsos

6 DATE OF BIRTH (month, day, and year): unknown 1887

7 AGE: Years 40 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Bethelehem Steel Co

9 BIRTHPLACE (city or town):

(State or country) Hungaria

PARENTS

10 NAME OF FATHER: John Barsos

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Hungaria

12 MAIDEN NAME OF MOTHER: Unk

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Hungaria

14 Informant: Ester Barsos

(Address) Sparrows Station

15 Filed ..... 192.. Registrar

JUL 13 1927 HEALTH DEPARTMENT BALTIMORE MD.

Per RAC

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry, inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:*

Fractures of Skull

(duration) Instt yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed) J. C. Gadd M. D.

(Coroner)

(Address) 1436 E Biay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Date of Burial July 20 1927

20 UNDERTAKER: F W Ozarowski ADDRESS 1750 Fostina

(If death should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24079

CERTIFICATE OF DEATH.

202

E 24079

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-2 Ward)

2-FULL NAME John J. Rychwalski

(a) RESIDENCE NO. 715 So First St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 29-1925,

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or....min.
	1	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) MD.

PARENTS

10 NAME OF FATHER John Rychwalski,

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimor, MD.

12 MAIDEN NAME OF MOTHER Sophia Pogowski,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Co/MD.

14 Informant Mrs. Sophia Rychwalski,

(Address) 715 So. First Street

15 Filed JUL 13 1927, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7- 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Strangulation

due to Hanging

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

July 18 27 (Signed) C. C. Jones M. D.

(Coroner)

(Address) 143 W. 1st Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy-Rosary Cemetery — Date of Burial July 20 1927.

20 UNDERTAKER M. F. Sadowski — ADDRESS 705 S. Ann St

(Cor.—12-9-25—A Co.—200 Bks.) Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24080

E 24080

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Md. General Hosp. St., 28-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Lentz

(a) RESIDENCE NO. 4407 Thornton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Lentz

6 DATE OF BIRTH (month, day, and year): May 11/1852

7 AGE: 75 Years 74 Months 2 Days 8 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Casper Wolf

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Hospital Record

(Address)

15 Filed ____, 19__ C. HAMPSON JONES, M. D. Registrar

Per ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

7-19-1927

17 I HEREBY CERTIFY, That I attended deceased from 7-17, 1927, to 7-19-, 1927,

that I last saw h.e alive on July 19, 1927,

and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, R. sided hemiplegia, Arterio-Sclerosis, Chronic Myocarditis

(duration) yrs. mos. 2½ ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

2½ hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Geo A. Mypatis, M. D.

, 19 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: July 21 1927

20 UNDERTAKER: H. N. Hymacost — ADDRESS: 4204 Hedgewood Ave.

Harry N. Hymacost

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24081 E 24081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST., WARD)

REGISTERED NO. 129 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary E - Hoffman.

(a) RESIDENCE NO. 40th - St - & Cedar Ave ST., Balto WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria - Va.

PARENTS

10 NAME OF FATHER Nehemiah Hicks

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Bayne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Home for Incurables (Address)

15 Filed July 7, 1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 - 15 - 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1. , 1927 , to July 18 , 1927 , that I last saw her alive on July 17. , 1927 , and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? O Date of O

Was there an autopsy? O

What test confirmed diagnosis? Laboratory

(Signed) Martin F. Moan M.D.

7/18, 1927 (Address) 411 Prof. Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem DATE OF BURIAL July 20 1927

20 UNDERTAKER John O Mitchell Sons ADDRESS 1900 Eutaw Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24082

E 24082

REGISTERED NO. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 419 N. Spring St. 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gilmore

(a) RESIDENCE NO. 419 N. Spring St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Gilmore

6 DATE OF BIRTH (month, day, and year): March 20, 1870

7 AGE: Years 57 Months 3 Days 27

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town): Boston, Mass

(State or country)

PARENTS

10 NAME OF FATHER: John Gilmore

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Hannah Jones

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Mrs Clara Gilmore (Address) 10 3 Son Chapel St

15 Filed ..... 19 .. C. BRAXTON JONES, M. D. Registrar

JUL 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17 1927

17 I HEREBY CERTIFY, That I attended deceased from June 7 1927 to July 17 1927

that I last saw h.. alive on July 17 1927

and that death occurred, on the date stated above at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) ... yrs. 9 mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Ewell Clement, M. D.

July 18 1927 (Address) 3 Gorsuch St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Evergreen Cemetery Date of Burial: July 20 1927

20 UNDERTAKER: Jones Chas G. Bailey ADDRESS: 1421 Jefferson St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24083

49 E 24083

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Cunningham

(a) RESIDENCE NO. 2112 Cambridge St. Ward 1-3

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) ?

14 Informant City Hospitals Records

(Address)

15 Filed ..... 19 ..... Registrar

L 19 1927 C. HARRISON JONES, M. D. RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1927

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1927, to July 18, 1927, that I last saw her alive on July 08, 1927, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of pancreas & obstructive jaundice

(duration) 2 yrs. mos. ds.

CONTRIBUTORY .....

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Surgical & Sub

(Signed) C. Hulbert Boyd, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Rosary	July 20 1927
20 UNDERTAKER	**ADDRESS**
John M. Weber	1803 Bond St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24084

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24084

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 S. Poppleton St. 18-29 WARD)

2-FULL NAME Infant Cusic

(a) RESIDENCE NO. 312 S. Poppleton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 19-1927

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. mn. 15 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Paul Cusic

11 BIRTHPLACE OF FATHER (city or town) (State or country): Marion Ohio

12 MAIDEN NAME OF MOTHER: Laura Butterworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Paul Cusic

(Address) 312 S. Poppleton St.

15 Filed 19 Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/19/27, to 7/19/27, 19, that I last saw h— alive on 7/19/27, 19, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cong. Atelectasis

(Abnormal Fetal state)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard Jung, M. D.

7/19/27 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemet. DATE OF BURIAL: July 20 1927

20 UNDERTAKER: Woolcook ADDRESS: 503 North Ave

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

(Blockinger)

E 24085

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24085

CERTIFICATE OF DEATH

44

REGISTERED NO. 21-31

1-PLACE OF DEATH

City of BALTIMORE: (No. 633 N Hamburg St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Harris Blockinger

(a) RESIDENCE NO. 633 N Hamburg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Married

5a. If married, widowed, or divorced (or) WIFE of Elizabeth

6 DATE OF BIRTH (month, day, and year) Apr 22 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer Self

9 BIRTHPLACE (city or town) .....

(State or country) Md

PARENTS

10 NAME OF FATHER Enoch Blockinger

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Md

12 MAIDEN NAME OF MOTHER Mrs Kinna

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Md

14 Informant Elizabeth Blockinger

(Address) 633 N Hamburg

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1927, to July 19, 1927,

that I last saw ~~him~~ alive on July 18, 1927,

and that death occurred, on the date stated above, at 4-05 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of throat

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Retention of Urine

(Signed) R J Sykes, M. D.

July 18 1927 (Address) Parkland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park July 21 19 27

Date of Burial

20 UNDERTAKER W Cole Sons Ext Ave

ADDRESS

C. HUMPSON JONES, M.D.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24086

E 24086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Roseland Turkish Bath (Equitable Bldg.) ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm A. Love

(a) RESIDENCE NO. 721 Walnut St ... St. Reading Pa Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Love

6 DATE OF BIRTH (month, day, and year)

7 AGE. Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
5-9			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Artist

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) Dow / Penn

(State or country)

PARENTS

10 NAME OF FATHER Clinton Love

11 BIRTHPLACE OF FATHER (city or town) St Louis Mo

(State or country)

12 MAIDEN NAME OF MOTHER Lutzmann

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Minnie Love

(Address) 721 Walnut St at Reading

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned - accidental

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

(Signed) W C Pulin M. D.

(Coroner)

July 1, 1927 (Address) 37 Penn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reading Pa. Date of Burial July 20 1927

20 UNDERTAKER Geo W Smith & Son ADDRESS 811 N Howard

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24087

CERTIFICATE OF DEATH

E 24087

X 7/4-001

REGISTERED NO. 24087

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 4-30 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ira J. Young

(a) RESIDENCE NO. Westminster Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie M. Young

6 DATE OF BIRTH (month, day, and year): Dec. 27 1862

7 AGE — Years: 65 Months: 5 Days: 6 (24)

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer (ob)

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: —

9 BIRTHPLACE (city or town): Westminster

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John Young

11 BIRTHPLACE OF FATHER (City or town): Westminster

(State or country): Md

12 MAIDEN NAME OF MOTHER: Sarilla Woods

13 BIRTHPLACE OF MOTHER (city or town): Carroll Co

(State or country): Md

14 Informant: Grace C. Williams

(Address): Westminster Md.

15 Filed ..... 19 .....

C. HANSON JONES, M. D.

JUL 20 1927

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1927

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1927, to July 19, 1927

that I last saw him alive on July 19, 1927

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (Apoplexy)

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted

If not at place of death? Westminster

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Lewis Aldo Taylor M. D.

, 19 (Address) Mercy Hosp Md Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Meadow Cem

Date of Burial: July 21 1927

20 UNDERTAKER: H Bankard & Son

ADDRESS: Westminster Md

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 24088

CERTIFICATE OF DEATH.

E 24088

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-11 Ward)

2-FULL NAME John Harvey Ingle

(a) RESIDENCE NO. 611 N. Potomac St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Jan 24/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	7	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Harvey Ingle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Rosalie Humphri

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant John Harvey Ingle

(Address) 611 N. Potomac St.

15 Filed JUL 20 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (Prob Bronchopneumonia)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

(Coroner)

7/19/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Olivet Cem. Colvert Co Md July 20 1927

20 UNDERTAKER ADDRESS

W. J. Cook 502 E. North Ave

Information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24089

CERTIFICATE OF DEATH.

90 E 24089

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1121 N Dallas St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah Green

(a) RESIDENCE NO. 1121 W. Dallas St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 70; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore City

(State or country)

PARENTS

10 NAME OF FATHER: John Jones

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Geo. Green

(Address) 1121 W. Dallas St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

Per ..... Registrar

20 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1927

17

I HEREBY CERTIFY, That I attended deceased from June 5 1927, to July 19, 1927, that I last saw h[illegible] alive on July 18, 1927, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

Ill 7 years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

7-19-1927 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leonard Town Date of Burial July 21 1927

20 UNDERTAKER: Theodore C Hirsh ADDRESS 113 S Wash St

DO NOT USE for county supplies. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 24090

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24090

1 PLACE OF DEATH Kernan Hospital

REGISTERED No. C

CITY OF BALTIMORE: (No. Windsor mill Road ; Hillsdale, Md. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elaine Parks

(Residence in Baltimore: No. Kernan Hospital, S. yrs. 7 mos. weeks ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH July (Month) 4 (Day), 1919. (Year)

7-AGE 7 yrs. 8 mos. 9 ds. If LESS than 1 day, 14 hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Crisfield, Md.

PARENTS

10-NAME OF FATHER Elijah Parks

11-BIRTHPLACE OF FATHER (State or country) Fairmont, Md.

12-MAIDEN NAME OF MOTHER Ida Brown

13-BIRTHPLACE OF MOTHER (State or country) Tylerton, Md,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eva Bonne Parks.

(Address) Crisfield Md.

15- Mar 4/25 1927 C. C. Collins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April (Month) 23 (Day), 1927. (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 26, 1927, to, Apr. 23, 1927, that I saw h She alive on Apr 22, 1927, and that death occurred, on the date stated above, at 5:45 P.m..

The CAUSE OF DEATH* was as follows:
Tuberculor meningitis

(Duration) yrs mos. 16 days.

Contributory (SECONDARY) Old tuberculor hip disease.

(3/12 Duration) 3½ yrs mos. ds.

(Signed), Cullustus Catlon M. D.

Apr. 23, 1927 [Address] Preston & St Paul Sts

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos 7 weeks In the State 8 yrs mos ds.

Where was disease contracted, if not at place of death? at Place of Death

Former or usual residence Columbia Ave. Crisfield, Md.

19-PLACE OF BURIAL OR REMOVAL Crisfield Md

DATE OF BURIAL April 26 1927

20-UNDERTAKER John A. Bradshaw

ADDRESS Crisfield Md

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JONES, M. D. SIMPSON, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24091

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

166 E 24091

REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene C. Waldhauser

(a) RESIDENCE NO. 2325 Milliman St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles M. Waldhauser

6 DATE OF BIRTH (month, day, and year) Sept 24/1895

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Eline

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Amar Biska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna.

14 Informant Chas. M. Waldhauser

(Address) 2325 Milliman St.

15 Filed ..... 19 (HAMPSON JONES, M. D.)

JUL 20 1927 Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poisoning.-Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Paten M. D.

(Coroner)

7/20/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State .....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New Cathedral	July 20 1927

20 UNDERTAKER William G. Schaeffer ADDRESS 1867 Fremont

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24092

CERTIFICATE OF DEATH.

E 24092

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) City Hospital (St.) 2636 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Celio

(a) RESIDENCE NO. Susquehanna River Road (St.) 2nd (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Celio

6 DATE OF BIRTH (month, day, and year) Sept. 1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
47		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Worker at

(b) General nature of industry, business, or establishment in which employed (or employer) Bethl. Steel Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER Carmine Celio

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Thelma Difiore

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Mary Celio (Wife)

(Address) 630 S. 12th St.

15 Filed ..... 19.....

JUL 26 1927 C. HAWKS JONES, M. D. Per K K – Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

Herefrom and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Gun Shot wounds

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

Signed July 17 1927 (Coroner) C. Pfaff M. D.

19 (Address) 143 Bl 3 way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial July 21st 1927

20 UNDERTAKER Lilly & Zucca ADDRESS 408 S. Wolfe St

Dated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated tion should be carefully supplied.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24093

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 24093

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2575 Frederick Rd ST., 20-69 WARD)

2-FULL NAME Lillian Irene Shuckart

(a) RESIDENCE NO. 2575 Frederick Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Sept 16th 76

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
50.	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Pearman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mollie Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John L Shuckart (Address) 2575 Frederick Ave

15 Filed , 19 Registrar RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1927

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1927, to July 16, 1927, that I last saw him alive on July 16, 1927, and that death occurred, on the date stated above, at 5.10 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lung

Tuberculosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Chronic Nephritis (duration) yrs. 5 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive

(Signed) Dr. Bond Thomas, M. D.

7-17 1927 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem — DATE OF BURIAL July 20th 1927

20 UNDERTAKER A. Jones — ADDRESS 111 S. Gilmor St

TION is very important. See instructions on back of certificates.

Exact statement of OCCUPA-

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24094 — 117 — E 24094

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Provident Hospital (St.) 16 (Ward) 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Jordan

(a) RESIDENCE NO. 918 N. Arlington St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE: ~~36~~ 39 Years — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 870

(b) General nature of industry, business, or establishment in which employed (or employer): Furniture Store

(c) Name of employer: Brent Co.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: David Jordan,

11 BIRTHPLACE OF FATHER (City or town) (State or country): Martinsburg Va.

12 MAIDEN NAME OF MOTHER: Martha Fields

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Middle Sex Co. Va.

14 Informant: Martha Fauntroy

(Address) 918 Saratoga St.

15 Filed ..... 19 ..... Per ..... Registrar

HAMPDEN JONES, M. D.

UL 26 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/17/1927

17 I HEREBY CERTIFY, That I attended deceased from 7/11/27, to 7/17/27, that I last saw h[illegible] alive on 7/17/27, and that death occurred, on the date stated above, at 9 45 m.

The CAUSE OF DEATH* was as follows:

Acute peritonitis

Ruptured appendix

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 7/11/27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Blackwood, M. D.

7/17, 1927 (Address) 508 Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — Date of Burial: July 21, 1927

20 UNDERTAKER: Eugene Payne — ADDRESS: 570 W. Preston St.

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24095

CERTIFICATE OF DEATH.

100-001

E 24095

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hosp. St., 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses V. Strouse

(a) RESIDENCE NO. 632 N. Fayette St City Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 Cor. yrs. mos. ds.

(If non-resident, give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): ~~Single~~ Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Strouse

6 DATE OF BIRTH (month, day, and year): July 31, 1860

7 AGE. Years: 66 Months: 11 Days: 18. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Photographer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Pa

(State or country)

PARENTS

10 NAME OF FATHER: Silas Strouse

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Moses Strouse

(Address): 632 N. Fayette St. City

15 Filed ..... 19..... Registrar

JUL 20 1927

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-19 1927

17

I HEREBY CERTIFY, That I attended deceased from July 9, 1927, to 7-19, 1927,

that I last saw h~~er~~ alive on 7-19, 1927,

and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. L. Palagliacco, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia, Pa. Date of Burial: 7/20/27

20 UNDERTAKER: Ward Sondheim ADDRESS: 118-20 W. Mt. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24096 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-001 E 24096

1-PLACE OF DEATH Union Memorial Hosp. REGISTERED NO. 26-37

City of BALTIMORE: (No. ____ St. ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby George Erhardt Jr.

(a) RESIDENCE NO. 220 S. 16th St. St. ____ Ward ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. If of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 26 1927

7 AGE Years ____ Months ____ Days 2 mos. IF LESS than 1 day ____ hrs. or ____ min..
8 weeks

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ____
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer ____

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER George Erhardt.

11 BIRTHPLACE OF FATHER (City or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Alice Rose

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mother
(Address)

15 Filed ____, 19 ____ Registrar

C. HAMPSON JONES, M. D.
JUL 20 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 7/20/27

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to July 20, 1927, that I last saw him alive on July 20, 1927, and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Spina Bifida
Hydrocephalus

Since birth (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Operation

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? yes Date of 7/18/27

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) James Cullen Bowles M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holly Redeemer — Date of Burial July 21 1927

20 UNDERTAKER F. A. Krauss Son — ADDRESS 703 Hanover St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24097 ✓ 113 E 24097

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 444 E. Clement X St., 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Chambers Gillece

(a) RESIDENCE NO. 444 E. Clement X St. ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Jan. 5, 1927

7 AGE — Years: 6 — Months: 14 — Days: .....

If LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore.

(State or country)

PARENTS

10 NAME OF FATHER Bernard Chambers Gillece

11 BIRTHPLACE OF FATHER (City or town) unknown

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Gillece

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Bernard G. Gillece

(Address) 444 E Clement

15 Filed ..... 19 .....

JUL 20 1927 HAMPSON JONES, M. D.

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1927, to July 19, 1927, that I last saw h— alive on July 19, 1927, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bacteriocolitis.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) John A. Schenuit, M. D.

19 (Address) 1337 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial July 19 1927

20 UNDERTAKER Margaret F. Flynn ADDRESS 1111 Eutaw St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24098 — CERTIFICATE OF DEATH. 32 — E 24098

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hosp. (St.) 19-27 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vera Combs

(a) RESIDENCE NO. 1524 W. Fayette St (St.) (Ward)
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-5-.2.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	16	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. Combs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D.C.

12 MAIDEN NAME OF MOTHER Minnie Eben Lack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Minnie Coombs
(Address) 524 W. Fayette St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-16 , 1927 , to 7-19 , 1927 ,
that I last saw h W alive on 7-19-27 , 19 ,
and that death occurred, on the date stated above, at 1:05 P m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Tuberculous

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Repeated Lumbar Punctures. Date of
Was there an autopsy?
What test confirmed diagnosis? Labor + Clinical

(Signed) My Lon S. Tull , M. D.
, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: July 25 1927

20 UNDERTAKER: George J. Smith — ADDRESS: Hollins

JUL 20 1927 — C. HAMILTON JONES, M. D. — Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24099 E 24099

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 Louisa Ave. St. Hamilton Ward) 27 43

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Gruninger

(a) Residence No. 7 Louisa ave. St. Hamilton Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie M. Gruninger

6-DATE OF BIRTH (month, day and year) Aug 6th 1872

7-AGE, 54 yrs. 11 mos. 13 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Window Glazer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Sash Factory

(c) Name of employer Bentley, Selmon Co.

9-BIRTHPLACE (city or town) Balto (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Henry Gruninger

11-BIRTHPLACE OF FATHER (city or town) Unknown (State or Country) Germany

12-MAIDEN NAME OF MOTHER Hermina Miller

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country) Germany

14- (Informant) Carrie M. Gruninger (Address) 7 Louisa ave. Hamilton

15-

Filed 7 20 1927 192

C. HAMPSON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 19th 1927

17- I HEREBY CERTIFY, That I attended deceased from August 6 1923 to July 19 1927 that I last saw h[illegible] alive on July 19 1927 and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

7/20, 1927 (Address) Hamilton Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Olivet Cemetery	July 21, 1927
20-UNDERTAKER.	ADDRESS
Frederick Lee Armstrong	Fullerton

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24100 ✓

E 24100

REGISTERED NO. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 17-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A Barry

(a) RESIDENCE NO. 971 George St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 29 ? Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer - Odd

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant

(Address)

15 Filed ..., 19 ... Registrar

C HAMPSON JONES, M. D.

Per

1549

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 16, 27

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1926 to July 16, 1927.

that I last saw him alive on July 16, 1927

and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

1 Bilateral Pulmonary Tuberculosis
Tuberculous Ulceration of Skin
2
(duration) Pulmonary mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs X Ray

(Signed) J. B. Russell, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

JUL 20 1927

LIBRARY

Fill should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

(Dorsey)

E 24101

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24101

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals

2-FULL NAME Viola Dorsey

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 223 W. Biddle St. 11-24 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Grandy

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant City Hospitals Records

(Address)

15 Filed ..... 19 .....

JUL 20 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/15/1927

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1927, to July 15, 1927, that I last saw h.. alive on July 13, 1927, and that death occurred, on the date stated above, at 11:00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis chronic acute
Bronchial pneumonia

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms + Exam

(Signed) C. Hubbard Boyd M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Lacrosse Lawn Cem	7/20 1927
20 UNDERTAKER	ADDRESS
J. F. Schuppert Sons	318 Light

Should be carefully supplied. Ages should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 113 E 24102

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Kaminsky

(a) RESIDENCE NO. North Pt. Rd. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-25-27

7 AGE Years 0 Months 2 Days 24 IF LESS than 1 day ..... hrs. or ..... min.

2 1/2 mos

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md -

(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (City or town)

(State or country) —

12 MAIDEN NAME OF MOTHER Annie Kaminsky

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) —

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 27 1927 19 H. HENDERSON JONES, M. D. Registrar

RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1927

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1927, to July 19, 1927, that I last saw him alive on July 19, 1927, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Marasmus

Acute Gastro-intestinal Indigestion

Entero-colitis

(duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? No. point Road

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Kolbrun, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Sacred Heart of Mary July 21 1927

20 UNDERTAKER — ADDRESS

John M Weber 1803 Eastern Ave

FROM ABOVE BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24103

CERTIFICATE OF DEATH 159-002

E 24103

REGISTERED NO. 20-69

1-PLACE OF DEATH

City of BALTIMORE: (No. 424 Furrow Street St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Ellen Dolle

(a) RESIDENCE NO. 424 Furrow Street St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
July 7, 1927

7 AGE Years Months Days IF LESS than 1 day ..... hrs. or ..... min..
12

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Dolle

11 BIRTHPLACE OF FATHER (City or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Olia A. Richardson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. George W. Dolle
(Address) 424 Furrow Street

15 Filed ..... 19 .....
C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
July 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to July 19, 1927, that I last saw her alive on July 17, 1927, and that death occurred, on the date stated above, at 10:20 A. m.

The CAUSE OF DEATH* was as follows:
Patient tuberculous
Acute
(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted —
If not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical examination

(Signed) James L. Fitzpatrick M. D.
7/19/1927 (Address) 1729 W. Lombard Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	7/21/27 19
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W. Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24104

CERTIFICATE OF DEATH.

182 E 24104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Jackson Wst. St. 3-5 Ward)

2-FULL NAME Michael McDermott

(a) RESIDENCE NO. 419 N Central St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH In plain terms, so that it may be properly classified. PHYSICIANS should state CAUSE very important. See instructions on back of certificate. EXACTLY.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 71; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired City Employee

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas McDermott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Caverly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant: Frank Scally

(Address) 434 Covington St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

JUL 20 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Acc Drowning.

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

Duration yrs. mos. ds.

July 20th 1927 (Coroner) C. Hodes M. D.

(Address) 1436 N Gay

State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cem. Date of Burial July 21 1927

20 UNDERTAKER Margaret A. Flynn ADDRESS 1411 Light St.

Spec.—1-12-23—M&T—500 Blks.

E 24105

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24105

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 840 E. 35th St. ST. 13-52 WARD)

2-FULL NAME Jean Buttington

(a) RESIDENCE (Usual place of abode) No. 840 E. 35th St. ST., 13 WARD .....

Length of residence in city or town where death occurred — yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 22-1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
—	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George E. Buttington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucie N. Mullinix

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant George E. Buttington (Address) 840 E. 35th St.

15 Filed July 20 1927 P.M. C. THAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20-1927

17

I HEREBY CERTIFY, That I attended deceased from July 2, 1927, to July 20, 1927.

that I last saw h— alive on July 20, 1927.

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

broncho pneumonia

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Wm. [illegible] M. D.

(Address) 3424 Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	July 21-1927

20 UNDERTAKER Horace H. Burgee ADDRESS 621 Fallsway

CAUSE OF DEATH in plain terms, so that a correct classification may be made. See instructions on back of certificates. TION is very important.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24106

CERTIFICATE OF DEATH.

33 ✓ E 24106

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1515 E Madison ST., 7-13 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M Joyce

(a) RESIDENCE NO. 1515 E Madison ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
1=	C	Married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Robert P Joyce

6 DATE OF BIRTH (month, day, and year) June 7 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 3 / 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chas Co Md.

PARENTS

10 NAME OF FATHER Robert Hutchins

11 BIRTHPLACE OF FATHER (city or town) Chas. Co Md.
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Helen Joyce (Daughter)
(Address) 1515 E Madison St

15 Filed ..... , 19 ..... Registrar K K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1927

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to July 19, 1927, that I last saw h[er] alive on July 18, 1927, and that death occurred, on the date stated above at 12 55 A m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Probably Tuberculosis unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Yaudy, M. D.

7/18, 1927 (Address) 1124 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Asbury Cemetery July 21 1927

20 UNDERTAKER — ADDRESS
Jos. J. H. Rochester 1913 Jefferson St

TION is very important. See instructions on back of certificates.

L 21 1927 C. HAMPSON JONES, M. D.

Per

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24107

90

REGISTERED NO. E 24107

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital Ward) 17-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Johnson

(a) RESIDENCE NO. 609 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 13 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Moses Johnson

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mabel Spelts

13 BIRTHPLACE OF MOTHER (City or town) Baltimore

(State or country) Md

14 Informant Mrs. John Pyle

(Address) 609 Aisquith Street

15 Filed JUL 21 1927 19 THOMAS JONES

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19/ 19 27

17 I HEREBY CERTIFY, That I attended deceased from 6/29/27, 19, to 7/19/27, 19, that I last saw him alive on 7/19/27, 19, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis with decompensation

(duration) ? yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Respiration, failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lawrence Fahrney M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — Date of Burial July 21 1927

20 UNDERTAKER: Robt. N. Geddes — ADDRESS [illegible]

IF ANSWERS are NOT KNOWN, or CERTAIN, say so. Do not guess. GIVE FULL AND CORRECT ANSWERS to all questions. Cause of death must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24108

CERTIFICATE OF DEATH.

188-003

E 24108

REGISTERED NO. 13-54

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Agnes Hosp St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hugh D. Brisco Sr

(a) RESIDENCE NO. 2425 McCulloh St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Brisco

6 DATE OF BIRTH (month, day, and year): Jan 2 / 1890

7 AGE: Years 37 Months 6 Days 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): Balto. P. Co.

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Joseph H. Brisco

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Alice E. Johnson

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant (Address): Mamie Brisco 2425 McCulloh St

15 Filed ..... 19 ..... Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Fract Spine

4 hours.

(duration) ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Auto Skidded - Driving Auto Self

(duration) ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

July 19 1927 (Address) Curtis Bay, Balto, Md

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem July 21 27

Date of Burial

20 UNDERTAKER: Samuel Hemsley ADDRESS 578 E Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 21 1927 C. HAMPTON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24109 — CERTIFICATE OF DEATH. — 45 E 24109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 S. Clinton ST., 26-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Robert Ratsch

(a) RESIDENCE NO. 800 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Djvorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth M.

6 DATE OF BIRTH (month, day, and year) Apr 7, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	67	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engr.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John H. Ratsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanah Stiels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John C. Ratsch
(Address) 800 S. Clinton St.

15 Filed JUL 21 1927 19 K.P.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1927

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1927, to July 20, 1927, that I last saw h alive on July 19, 1927 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ✓ if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry B. Athey, M. D.

7/20 1927 (Address) 2504 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Carmel Cemetery — DATE OF BURIAL July 22 1927

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E. Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24110

CERTIFICATE OF DEATH.

E 24110

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 25-72 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Russell

(a) RESIDENCE NO. Monongah W. Va St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Russell

6 DATE OF BIRTH (month, day, and year) Jul 14/1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER James W. Boggess

11 BIRTHPLACE OF FATHER (city or town)

(State or country) W. Va

12 MAIDEN NAME OF MOTHER Eunice Fleming

13 BIRTHPLACE OF MOTHER (city or town) W. Va

(State or country)

14 Informant Thomas Russell

(Address) Monongah W. Va

15 Filed 19 C. HAMILTON JONES, M. D. Registrar

Per

JUL 21 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-6, 1927, to 7-20, 1927, that I last saw h..... alive on 7-20, 1927, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/12/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. L. Daggett M. D.

, 19 (Address) St Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmont W. Va Date of Burial July 21 1927

20 UNDERTAKER Chas. E Franck ADDRESS 802 Madison Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 24111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1/2 E 24111

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (T.B.) St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Beach

(a) RESIDENCE NO. 928 Shields Place St. 11-24 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Unknown mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)
1897

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed , 19 Registrar

JUL 21 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
July 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 16, 19 27, to July 18, 19 27, that I last saw him alive on July 18, 19 27, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
Tuberculous meningitis
(duration) Unknown yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. [illegible], M. D.

7-18-27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

National Cem 7/21 1927

20 UNDERTAKER — ADDRESS

Samuel Zanton 916 Pean

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24112

CERTIFICATE OF DEATH

× 74-002

REGISTERED NO. E 24112

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital of Balto. Co.

City of BALTIMORE: (No. Pinkerville Balto Co. Ward 13

2-FULL NAME Thomas Wallmee

(a) RESIDENCE NO. Butler Balto. Co. St. Ward Maryland

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Whit

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 67 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 068

(b) General nature of industry, business, or establishment in which employed (or employer): School Teacher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: Josiah Mallonee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Tracey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: Josiah Mallonee

(Address) Butler Balto Co.

15 Filed JUL 21 1927 19 CHARLES H. JONES, M. D. Per H.K.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 7/20/27

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to July 20, 1927, that I last saw him alive on July 20, 19 27, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows: Thrombosis of L. Femoral Vein

CONTRIBUTORY (Secondary): Cerebral embolus (duration) ..... yrs. ..... mos. ..... ds.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Edmund Levin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Black Rock Balto. Co. Date of Burial July 22 1927

20 UNDERTAKER: W. C. Brooks

ADDRESS: Black Rock, Md

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Phila Rd. 92

E 24113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 1217 North 62nd ST. 26-38 WARD)

2-FULL NAME Anna M. Behr.

(a) RESIDENCE NO. 1217 North 62nd Street. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Behr.

6 DATE OF BIRTH (month, day, and year): Oct. 21, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	61	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Michael Weisel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): George Behr 1217 North 62nd St.

15 Filed JUL 21 1927, 19 Per RPK. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 19 27, to July 19, 19 27, that I last saw her alive on July 19, 19 27 and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis
Arteriosclerosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds. —

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Krause, M. D.

, 19 (Address) 20 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: July 22 1927

20 UNDERTAKER: John J. Moran

ADDRESS: 3000 E. Balto St.

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-002

E 24114

REGISTERED NO.

E 24114

1-PLACE OF DEATH

City of BALTIMORE: (No. 1115 N. Montford ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Brooks

(a) RESIDENCE NO. 1115 N Montford ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married, Widowed~~, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 27 - 1919

7 AGE: Years 8 Months 6 Days 23. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER James H Brooks

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Theresa J Maguire

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant

(Address) 1115 N. Montford ave

15 Filed JUL 27 1927, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1927

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1927, to July 20, 1927

that I last saw her alive on July 20, 1927

and that death occurred, on the date stated above, at 9 30 p. m.

The CAUSE OF DEATH* was as follows:

Diphtheritic Myocarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diphtheria (carr)

(duration) yrs. mos. 11 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Laboratory test

What test confirmed diagnosis?

(Signed) H. L. Kessler, M. D.

(Address) 1301 N Broadway

*(State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — Date of Burial: July 22 1927

20 UNDERTAKER: Robt J Turner — ADDRESS: 1342 N Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Dr Dellcrett 2800 Garrison Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24115

CERTIFICATE OF DEATH.

129 E 24115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2402 Arunah Ave ST. 16-69 WARD

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gengeonna Giesebrecht

(a) RESIDENCE NO. 2402 Arunah Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

TION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Oscar Giesebrecht

6 DATE OF BIRTH (month, day, and year): Aug 23, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	71	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Genoa

PARENTS

10 NAME OF FATHER: James Bragonds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga

12 MAIDEN NAME OF MOTHER: Henrietta Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Oscar Giesebrecht
(Address) 2402 Arunah Ave

15 Filed JUL 27 1927 19 Det. RM, Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1927

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1927, to July 20, 1927, that I last saw her alive on July 19, 1927 and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis
(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Tests.

(Signed) J. M. Dellcrett, M. D.

July 20, 1927 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: July 22 1927

20 UNDERTAKER: H. M. Cook

ADDRESS: 507 E Northern

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24116

CERTIFICATE OF DEATH.

44

E 24116

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1509 W. Lanvale St. ST. 16-22 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Precilla Edmons

(a) RESIDENCE NO. 1509 W. Lanvale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Edmons

6 DATE OF BIRTH (month, day, and year) Oct. ? 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	9	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tapahanock Va.

PARENTS

10 NAME OF FATHER Dan. Pendleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Maria Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Wm. Minters

(Address) 1525 W. Mulberry St.

15 Filed JUL 21 1927 C. HAMPTON JONES, M. D. Registrar RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18. 1927

17

I HEREBY CERTIFY, That I attended deceased from July 16th, 1927, to July 18th. 1927.

that I last saw her alive on July 18th, 1927,

and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinomata

(duration) 2 yrs. ? mos ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Jackson, M. D.

7-20 1927 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL July 21 1927

20 UNDERTAKER Wm. M. Chase & Son ADDRESS 1400 Madison

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 ✓

E 24117

E 24117

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. South Balto Gen. Hosp. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Stuhr

(a) RESIDENCE NO. 1330 Washington Blvd. Ward 2-29

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. W. Stuhr

6 DATE OF BIRTH (month, day, and year): March 25, 1883

7 AGE — Years: 44 | Months: 3 | Days: 24 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: James E. Fields

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Virginia Henesburger

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Maryland

Informant: Chas. W. Stuhr

(Address): 1330 Washington Blvd.

d....., 19..... HAMPSON, Jones, M. D.

Registrar

Par RRA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 12 19 26 to July 19, 19 27, that I last saw her alive on July 19, 19 27, and that death occurred, on the date stated above, at 11 30 P.m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) metastasis to the Brain (duration) yrs. 2 mos. 14 ds.

18 Where was disease contracted if not at place of death? 1330 Washington Blvd

Did an operation precede death? No Date of May 1926

Was there an autopsy? No

What test confirmed diagnosis? Pathological

(Signed) Jones A. H. Hampson, M. D.

19 (Address) 827 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery Date of Burial 7/23/27 19

20 UNDERTAKER: Joseph B Cook ADDRESS 1003 W. Baltimore St

* DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Irons

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24118

CERTIFICATE OF DEATH

164

E 24118

1-PLACE OF DEATH Aged Womens Home — REGISTERED NO.

City of BALTIMORE: (No. 1400 W Lexington St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah E. Irons

(a) RESIDENCE NO. 1400 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 23, 1840

7 AGE — Years: 87 — Months: 6 — Days: 17 — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Dominick Miller

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret S. Euler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Ella F. Jones

(Address) 1400 W Lexington St

15 Filed ..... 19 ..... C. HAMPSON LEE, M. D. Registrar

JUL 21 192 Per R Toll

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1927 to July 19, 1927

that I last saw h alive on July 19, 1927

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows: Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin B Jones M. D.

19 (Address) 1105 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park	July 21 1927
20 UNDERTAKER	ADDRESS
George J. Smith	153 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks. Letter in file from Morris N. Patterson MD Dated 8-22-27

E 24119

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44X

E 24119

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2420 Trait ave St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie V. Hanbel

(a) RESIDENCE NO. 2420 Trait ave St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 4 mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Hanbel

6 DATE OF BIRTH (month, day, and year) May 12 1869 1872 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
58	55	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Penna

(State or country)

PARENTS

10 NAME OF FATHER Jacob Snyder

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Penna

12 MAIDEN NAME OF MOTHER Katie Arvig

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna

14 Informant Everett W. Hanbel

(Address) Kobby P.O. Richmond Co. Va.

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

21 1927 Per Rock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to July 21, 1927, that I last saw h.. alive on July 18, 1927, and that death occurred, on the date stated above, at 3/5a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach

(duration) Not known yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray & laboratory tests

(Signed) M. N. Patterson, M. D.

July 21 1927 (Address) 2324 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Farnham Ecun. Va. Date of Burial July 22 1927

20 UNDERTAKER Lilly & Julee ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24120

E 24120

CERTIFICATE OF DEATH 161-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 27-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby West (Kenneth)

(a) RESIDENCE NO. 405 Strathmore Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-12-27

7 AGE Years Months Days 7

IF LESS than 1 day ..... hrs. or ..... min..

6 hours

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Kenneth - West

11 BIRTHPLACE OF FATHER (City or town) Ind

(State or country)

12 MAIDEN NAME OF MOTHER Della Hurley

13 BIRTHPLACE OF MOTHER (city or town) Ind

(State or country)

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

JUL 21 1927 1553 BPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1927, to July 19, 1927, that I last saw h e alive on July 19, 1927, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) I. Ridgeway Trimble, M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL JUL 21 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24121

CERTIFICATE OF DEATH.

E 24121

REGISTERED NO. 148

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Bon Secours Hos. St.; WARD) 27

2-FULL NAME Grace Strasbaugh

(a) RESIDENCE NO. Belair. R. F. D. Md. St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. P. Strasbaugh

6 DATE OF BIRTH (month, day, and year): Apr 18-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Jeffrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wm. P. Strasbaugh (Address) Belair. Md. R. F. D.

15 Filed 21 1927, 19 ... Registrar ... C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1927, to July 21, 1927, that I last saw her alive on July 21, 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Toxaemia of Pregnancy

(duration) yrs. 8 mos ... ds.

CONTRIBUTORY (Secondary) Post partum shock 8 hours

(duration) yrs. ~~mos.~~ ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of July 20/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George O. Eaton, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairview by Md Churchville Pres. Cem. DATE OF BURIAL: July 23 1927

20 UNDERTAKER: Wm. J. Tucker & Sons ADDRESS: N. Ave

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 24122

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24122

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 214 S Gilmore ST., 19-28 WARD.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Beares

(a) RESIDENCE NO. 214 S Gilmore ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Beares

6 DATE OF BIRTH (month, day, and year) Dec 3-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Ry & Elect Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Co

PARENTS

10 NAME OF FATHER George Beares

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co

12 MAIDEN NAME OF MOTHER Elizabeth Blakey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co

14 Informant Gertrude M. Beares
(Address) 214 S Gilmore St

15 Filed [illegible], 19[illegible] [illegible] Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1925, to July 19, 1927, that I last saw h[illegible] alive on July 12, 1927 and that death occurred, on the date stated above, at 7:15 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of June 5/1925

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Buxton, M. D.

7/19 1927 (Address) 201 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL July 22nd 1927

20 UNDERTAKER John J Bowan & Son ADDRESS 901 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 21 1927

Spec.—1-12-23—M&T—500 Blks.

E 24123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24123

129

16-23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 95-4 Harlem Ave (St.) (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Bethania Counihan

(a) RESIDENCE NO. 95-4 Harlem Ave St., Ward .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19-1856

7 AGE	Years	Months	Days	If LESS than 1 day, brs. or min.
	70	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sister of Sacred Heart.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

065

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Do Not Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Do Not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Sister M. Harriet. 95-4 Harlem ave

15 Filed ..... 19 ..... Registrar

1927 C. HAMPSON JONES, M. D.

Via B+O R.R. Escort Sister Assumpta.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to July 20, 1927, that I last saw h[illegible] alive on July 20, 1927, and that death occurred, on the date stated above, at 5.20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Int. Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. P. Healy M. D.

July 22, 1927 (Address) 2225 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notre Dame, Ind.

DATE OF BURIAL 7-27-27.

UNDERTAKER Martin Faley & Son

ADDRESS 1821 North Ave.

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24124 E 24124

CERTIFICATE OF DEATH

113

1-PLACE OF DEATH REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Vincent

(a) RESIDENCE NO. St. Vincents Home St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married, Widowed~~, or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Do not know

7 AGE: Years 0 Months 4 Days 0 — IF LESS than 1 day ..... hrs. or ..... min.

4 Mos

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (City or town): Do not know

(State or country)

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town): Do not know

(State or country)

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

JUL 21 1927 C. HAMILTON JONES, M. D.

Per RPA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1927

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1927, to July 20, 1927, that I last saw her alive on July 19, 1927, and that death occurred, on the date stated above, at 12:35 P.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Intestinal Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: 7-22-27

20 UNDERTAKER: M. Lahey & Sons — ADDRESS: [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24125

CERTIFICATE OF DEATH

74-002

E 24125

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General Hospital (St.) (Ward) 11-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Stonesifer

(a) RESIDENCE NO. Westminster, Md. Route # 2 St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Stonesifer

6 DATE OF BIRTH (month, day, and year): 11-4-1866

7 AGE: Years 60 Months 8 Days 17 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. Md. (State or country)

PARENTS

10 NAME OF FATHER Abraham Zepman

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Petry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hosp. Records (Address)

15 Filed 2 1927 19 C. HAMPSON JONES, M. D. Registrar Per R.R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21-27 19

17 I HEREBY CERTIFY, That I attended deceased from 7-12-27, 19, to 7-21-27, 19, that I last saw h[illegible] alive on 7-21-27, 19, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Cholecystitis

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) hidden yrs. mos. ds.

18 Where was disease contracted if not at place of death? hidden

Did an operation precede death? yes Date of 7-13-27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

, 19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodsen Westminster Md. Date of Burial: July 25 19 27

20 UNDERTAKER: H. Bankard & Son ADDRESS: Westminster Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24126 44 E 24126

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 11-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Blalock

(a) RESIDENCE NO. 611 N Calvert St. Ward

(Usual place of abode) Baltimore

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE: Years 47 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 862

(c) Name of employer

9 BIRTHPLACE (city or town) Ga

(State or country)

PARENTS

10 NAME OF FATHER A. P. Blalock

11 BIRTHPLACE OF FATHER (City or town) Ga

(State or country)

12 MAIDEN NAME OF MOTHER Minnie Poole

13 BIRTHPLACE OF MOTHER (city or town) Ga

(State or country)

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

C. HAMPSON JONES, M. D.

JUL 21 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-13- 1927 to 7-18- 1927

that I last saw h.. alive on July 18, 1927

and that death occurred, on the date stated above, at 12:40 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

Months

(duration)

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray & Oesophagoscope

(Signed) M.D.

19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greensville Ga — Date of Burial: July 21 1927

20 UNDERTAKER: Mr - Mrs M S Trail — ADDRESS: 2012 Hollins Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24127

CERTIFICATE OF DEATH. 122-002

E 24127

REGISTERED NO. 11-15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1212 Guilford Av St., 11-15 Ward)

2-FULL NAME Geo. B. Pittman

(a) RESIDENCE NO. 1212 Guilford Av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Pittman

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of Industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Ed. B. Pittman

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER A. Barrett

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs. Pittman
(Address) 1212 Guilford Av

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis
Cerebral Hem
Duration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis
(duration) yrs. mos. ds.

Signed July 21 192 (Coroner) M. D.
(Address) 1034 Dru

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral cem Date of Burial 7/22 1927

20 UNDERTAKER J. J. Fahey Sons ADDRESS 1218 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2 1927 C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

E 24128

HEALTH DEPARTMENT—CITY OF BALTIMORE (Copyholder)

CERTIFICATE OF DEATH

7A-001

REGISTERED NO. E 24128

1-PLACE OF DEATH

City of BALTIMORE: (No. 1700 Patapsco St. 23-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Michaux

(a) RESIDENCE NO. 1700 Patapsco St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H.

6 DATE OF BIRTH (month, day, and year) June 17, 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	69	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Stephen Prem

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Europe

12 MAIDEN NAME OF MOTHER Barbara

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Clarence J. Michaux

(Address) 206 E. Cross St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 19 1927

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1927 to July 20, 1927

that I last saw her alive on July 20, 1927

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Apoplexia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted —

if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. L. Campbell, M. D.

July 21 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Lorraine Cem	July 22 1927
20 UNDERTAKER Margaret E. Flynn	ADDRESS 1422 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

82944 E 24129 — 90 — E 24129

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (Street) 25-74 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Hall

(a) RESIDENCE NO. English Consulate St. Ward City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Olivia Edna Hall

6 DATE OF BIRTH (month, day, and year): July 16 1874

7 AGE — Years: 53 — Months: 0 — Days: 5 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Ohio
(State or country)

PARENTS

10 NAME OF FATHER: Chas. Hall

11 BIRTHPLACE OF FATHER (City or town): Ohio
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Hall

13 BIRTHPLACE OF MOTHER (city or town): Ohio
(State or country)

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 22 1927 19 — Per R.P.K. — Registrar — (HARRISON JONES, M. D.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27: July 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to July 21, 1927,
that I last saw h[illegible] alive on July 21, 1927,
and that death occurred, on the date stated above, at 10.20 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Aortic Regurgitation

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? –

(Signed) George S. Dennis, M. D.

7/21/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: July 23 1927

20 UNDERTAKER: J. Pius Sheeran & Sons — ADDRESS: Northern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Nannee Nisbet Alexander

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24130 — K 119 — E 24130

CERTIFICATE OF DEATH

REGISTERED NO. 12-44

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs George S. Alexander

(a) RESIDENCE NO. Savannah Georgia St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Geo. S. Alexander

6 DATE OF BIRTH (month, day, and year): Nov 22- 1880

7 AGE: Years 46 yrs Months 8 Days 29 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Savannah Geo.

(State or country)

PARENTS

10 NAME OF FATHER: John Nesbet

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Virginia King

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Hospital Record

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 July 21–

17 I HEREBY CERTIFY, That I attended deceased from July 7 1927 to July 21 1927

that I last saw her alive on July 21 1927

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Focal Fracture

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

20 hours (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 7-20-27

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) K. J. Pollard M. D.

7-21, 1927 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Savannah Ga. — Date of Burial July 22 1927

20 UNDERTAKER: Henry H. Jenkins Sons — ADDRESS McCulloh & Eutaw

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 E 24131

E 24131 1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Hopkins Hospital St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Williams

(a) RESIDENCE NO. 403 N. Central Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Oct 5/25

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N.C.

PARENTS

10 NAME OF FATHER Columbus Shaw

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N.C.

14 Informant Mary Williams

(Address) 403 N. Central Ave

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 July 20/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage-Fractured Skull- Accidently fell from 2nd story porch at residence.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

19 (Address) 7/22/27 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem'y Date of Burial July 22 19 27

20 UNDERTAKER Robert F. Williams ADDRESS 1515 N. Mc Elderry

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24132 40th & Cedar Av. 57 E 24132

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Home Incurables 13-14 (WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Konneker

(a) RESIDENCE No. Home Incurables ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female (White)

4 COLOR OR RACE:

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjo Konneker

6 DATE OF BIRTH (month, day, and year): apr 25 1861

7 AGE: Years 66 | Months 2 | Days 21 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas A. Konneker

(Address) 324 Cumberland Ave

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to July 20, 1927, that I last saw her alive on July 20, 1927 and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Arthritis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Marbury T. Mason, M. D.

7/28/1927 (Address) 415 St Paul Blg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: July 23 1927

20 UNDERTAKER: J. Frederick Sons

ADDRESS: Park

IMPORTANT. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24133

CERTIFICATE OF DEATH.

44 E 24133

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) St Agnes Hosp. St. 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Brotzman

(a) RESIDENCE NO. 209 S. Sticker St St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Frank Brotzman

6 DATE OF BIRTH (month, day, and year): Jan 26th 1875

7 AGE: Years 52 Months 5 Days 24 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER: John Griffin

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary McElgun

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland

14 Informant: Frank Brotzman

(Address): 209 S. Sticker St City

15 Filed ..... 19 C. HAMPTON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-20 1927

17

I HEREBY CERTIFY, That I attended deceased from 7-10 1927, to 7-20 1927, that I last saw h.. alive on 7-20 1927, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma = Metastatis Primary growth ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? Yes Date of 7/18/27

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Dadey Ciacco, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem Date of Burial: July 23 1927

20 UNDERTAKER: A. Jones ADDRESS: 1131 Gilmor st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 22 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24134

CERTIFICATE OF DEATH.

131

E 24134
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank K Howard

(a) RESIDENCE NO 434 S Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/21/1880

7 AGE: Years 46 Months 8 Days 29 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Foreman Water
(b) General nature of industry, business, or establishment in which employed (or employer): Dept
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Howard

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Margaret Howard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Balto Md

14 Informant: Mrs Herman Miller
(Address) 118 S Lakewood Ave

15 Filed ....., 19 .....

R/C Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1927

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Pyonephrosis

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) ..... yrs. ..... mos. 1 ds.

July 21/27 (Signed) G C Yates M. D. (Coroner)

(Address) 1437 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial 7/23 1927

20 UNDERTAKER: George F Ruth — ADDRESS 1735 Harford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24135 — REGISTERED NO. E 24135

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp. St., 47-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Busch

(a) RESIDENCE NO. 4922 Harford Rd. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	35	3	19 20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm H Busch

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Baltis Md

12 MAIDEN NAME OF MOTHER Caroline E Peters

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant William Busch
(Address) 4922 Hereford Ave

15 Filed ..... 19 ..... Registrar

JUL 22 1927 C. HAMPTON [illegible]

Per R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20-1927 19

17 I HEREBY CERTIFY, That I attended deceased from 7/16/27 to 7/20/27

that I last saw her alive on 7/20/27

and that death occurred, on the date stated above, at 10 or A. m.

The CAUSE OF DEATH* was as follows:

Possible brain tumor

(duration) about 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Respiratory failure

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No refused

What test confirmed diagnosis? clinical

(Signed) W. Lawrence Fahrney, M. D.

. 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — Date of Burial 7/23 1927

20 UNDERTAKER George J Ruth — ADDRESS 1735 Harford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Blks.

E 24136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

86 E 24136

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1742 Ashland ST., 7-13 WARD)

2-FULL NAME Anna Holoby

(a) RESIDENCE NO. 1742 Ashland ST., WARD

(Usual place of abode) (If non-resident-give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Married

5a If married, widowed, or divorced (or) WIFE of William N. Holoby

6 DATE OF BIRTH (month, day, and year) Nov. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Edward Co. Virginia

PARENTS

10 NAME OF FATHER John Booker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louisa Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Wm. Holoby Husband (Address) 1742 Ashland

15 Filed JUL 22 1927 19 Per R. C. Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1927, to July 19, 1927, that I last saw h[illegible] alive on July 19, 1927, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis — Acute Hypertension — Apoplexy

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) W. L. Bellis, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	July 21 1927
20 UNDERTAKER	ADDRESS
Wm. R. A. Elliott	725 Ashland Ave.

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24137

CERTIFICATE OF DEATH

31 E 24137

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 879 4 Howard 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifford Roach

(a) RESIDENCE NO. 879 4 Howard Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20, 1878

7 AGE — Years: 49. Months: 1 Days: 1

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer): Hecht Bros 066

(c) Name of employer

9 BIRTHPLACE (city or town): Virginia
(State or country)

PARENTS

10 NAME OF FATHER: Thomas B Roach

11 BIRTHPLACE OF FATHER (City or town)
(State or country): N Va

12 MAIDEN NAME OF MOTHER: Virginia Mankin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Balto Md.

14 Informant: Jenny L Anderson
(Address): 1 Rutland Centre Ft.

15 Filed ..... 19 ..... Registrar

JUL 22 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 8 1927, to July 21 1927, that I last saw h[illegible] alive on July 20 1927 and that death occurred, on the date stated above, at 4:15 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Both Lungs, do not Know (duration) 2 yrs. mos.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. do not Know mos.

18 Where was disease contracted

If not at place of death? do not Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) P. E. Kussell M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial July 25 19 27

20 UNDERTAKER: George Smith ADDRESS: 1632 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Mable

Spec.-7-17-26—A Co.—200 Bks.

E 24138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 24138

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 4701 Hamilton Ave St., Ward 43)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Mallet

(a) RESIDENCE NO. 4701 Hamilton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1852

7 AGE: 75 Years, 4 Months, 3 Days. IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER: Jacob C. Gerry

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Anastasia

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: J C Mallet

(Address): 4918 Liberty Heights Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: July 14 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 19 25, to July 19, 19 27,

that I last saw h alive on July 18, 19 27

and that death occurred, on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis - Eczema -

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis -

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H C Gerry, M. D.

7/11/27 19 (Address) 6 W Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: July 22 1927

20 UNDERTAKER: George J. Smith — ADDRESS: 153 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24139

CERTIFICATE OF DEATH.

1194 E 24139

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1307 Linden Ave ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elanor P. Fonder

(a) RESIDENCE NO. 1307 Linden Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Cornelius Fonder

6 DATE OF BIRTH (month, day, and year): Sept 20-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	82	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Annie Connolly

(Address) 1307 Linden Ave

15 Filed JUL 22 1927 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1927, to July 24, 1927, that I last saw her alive on July 21, 1927, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Age —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? by Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. R. Forsythe, M. D.

7/22, 1927 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: July 23 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North

IMPORTANT See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24140

CERTIFICATE OF DEATH.

E 24140

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4126 Old Pimlico Road (Ward) 45-38

2-FULL NAME Geo. Wm Botts

(a) RESIDENCE. No. 4126 Old Pimlico Rd. St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred? Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Katie Botts

6 DATE OF BIRTH (month, day, and year) Jan 16-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Painter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Herman Botts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Katie Botts
(Address) 4126 Old Pimlico Rd

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20. 1927

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to July 20, 1927, that I last saw h[im] alive on July 19, 1927, and that death occurred, on the date stated above, at 8-30 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma Endmarkly

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Miles Wheeler, M. D.

7-22 1927 (Address) 2129 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cem	July 23 1927
20 UNDERTAKER	ADDRESS
Josiah Syfers	1605 W. North Ave

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 24141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 ✓ E 24141

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Cardell

(a) RESIDENCE NO. 1810 N. Duncan st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Cardell

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Layman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Maggie Whenzil

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JUL 22 1927 19 C. HAMPTON JONES, M. D. Registrar

Per R H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 6, 19 27, to July 20, 19 27, that I last saw her alive on July 20, 19 27, and that death occurred, on the date stated above, at 2.10 p. m.

The CAUSE OF DEATH* was as follows:

Generalized carcinomatosis

Primary focus probably uterine carcinoma (duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

7-20-1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial July 23 1927

20 UNDERTAKER Frank V. Pepitone — ADDRESS 251 S E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24142

CERTIFICATE OF DEATH

117 ✓

E 24142

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hospital St. 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wienert

(a) RESIDENCE NO. 1718 Ashburton St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-25-07

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	19	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Bank

(c) Name of employer

9 BIRTHPLACE (city or town) Bretenoux Fd.

(State or country)

PARENTS

10 NAME OF FATHER Theodore Wienert

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Goerte

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ohio

14 Informant Hosp. Record

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

7-21-27

17 I HEREBY CERTIFY, That I attended deceased from 7-13-27, 19..., to 7-21-27, 19...,

that I last saw h(e) alive on 7-21-27, 19...,

and that death occurred, on the date stated above, at 1.40 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Gen. Peritonitis Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 7-13-27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

, 19 (Address) Bd. Govt Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

Date of Burial July 23 19 27.

20 UNDERTAKER Mrs. John W. Teufel & Son

ADDRESS 501 N. Fayette

JUL 22 1927 C. HAMILTON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 24143

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 S Bond ST. 24 WARD)

2-FULL NAME Miss Mary Hofmagel

(a) RESIDENCE NO. 219 S. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Balthasar Hofmagel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Ruppert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Leonard Hofmagel

(Address) 819 S Bond St

15 Filed JUL 21 1927 RK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/20 1927

17 I HEREBY CERTIFY, That I attended deceased from July 2 1927 to July 20 1927

that I last saw h er alive on July 19 1927,

and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Cortical Sclerosis, Chronic

Diffuse Nephritis, acute

Angina

(duration) yrs. mos 1 ds 7

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Ivy D Roberts, M. D.

(Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL July 23 1927

20 UNDERTAKER Wm C Hillerton ADDRESS 2334 Jeffers

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24144

CERTIFICATE OF DEATH

X 118-002

REGISTERED NO. E 24144

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lyndall Martin.

(a) RESIDENCE NO. Shipley Hyts Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~[illegible]~~ yrs. — mos. 10 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Paul J Martin

6 DATE OF BIRTH (month, day, and year): June 9 1891

7 AGE — Years: 36 Months: 1 Days: 13 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone cut

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Montgomery Co (State or country) Md

PARENTS

10 NAME OF FATHER: Isaac Newton Shipley

11 BIRTHPLACE OF FATHER (City or town): (State or country) Montgomery Co Md

12 MAIDEN NAME OF MOTHER: Mahala J Pyles

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Montgomery Co Md

14 Informant: Paul J Martin (Address) Shipley Hyts

15 Filed C H [illegible] 19 Registrar

JUL 22 1927 Per R H H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 12, 19 27, to July 22, 19 27,

that I last saw h[illegible] alive on July 22, 19 27,

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Peritonitis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Intestinal resection

Duodenitis.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Shipley Hyts.

Did an operation precede death? yes Date of July 12 27

Was there an autopsy? no.

What test confirmed diagnosis? Physical examination

(Signed) H H Hanna, M. D.

7. 22. 27 (Address) 822 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendship Cem A A Co — Date of Burial: JUL 21 1927 19

20 UNDERTAKER: Geo R Little — ADDRESS

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24145 — 1-PLACE OF DEATH — Margaret Neukam — BALTIMORE CITY HOSPITALS — 10 Ward — REGISTERED NO. E 24145

74-001

City of BALTIMORE: (No. [redacted] S. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Neukam

(a) RESIDENCE NO. 621 N. Belnord Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced (or) WIFE of: Mr. John Neukam

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years 72 Months Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: John Adelpener

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Carrie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

BALTIMORE CITY HOSPITALS

Informant [redacted]

(Address) Records

15 Filed ..... 19 .....

JUL 22 1927

C. HAMILTON JONES, M. D.

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/21/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1927, to July 21, 1927.

that I last saw h[illegible] alive on July 21, 1927

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - rt.

Cerebral Hemorrhage - left

Arterio-Sclerosis. Hypertension

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? General + Gross.

(Signed) C. Hamilton Jones M. D.

7/22/27, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial July 23 1927

20 UNDERTAKER: Henry Strech & Son — ADDRESS 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

7 34 E 24146

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

City of BALTIMORE: (No.) St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Lee Johnson

(a) RESIDENCE NO. St. Margarets (Annapolis St Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 11 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lorette Johnson

6 DATE OF BIRTH (month, day, and year): Unknown 1902

7 AGE: Years 25 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Abel Hayden

11 BIRTHPLACE OF FATHER (City or town) (State or country):

12 MAIDEN NAME OF MOTHER: Catherine Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed 7-24 1927 19 Registrar For RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 July 20 - 27

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1927, to July 20, 1927, that I last saw him alive on July 20, 1927, and that death occurred, on the date stated above, at 2.30 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spine with transverse myelitis

(duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary) Tuberculous Septicaemia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted

if not at place of death? St. Margaret Annapolis Md.

Did an operation precede death? Yes Date of July 12, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) [illegible] M. D.

7-21-1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Cem Annapolis Md

Date of Burial: July 23 1927

20 UNDERTAKER: Sam'l H. Chase & Son

ADDRESS: Woodlawn

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24147

CERTIFICATE OF DEATH

90

E 24147

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY H[illegible] St. 34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Brinsley

(a) RESIDENCE NO. 1442 Eastern Ave. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 30 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 BALTIMORE CITY HOSPITALS

Informant

(Address) Reisdo.

15 Filed [illegible] 19 C. HAMPSON JONES, M. D.

2 2 1927 Per [illegible] Registrar

1555

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/10/ 19 27.

17

I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1926, to July 18, 1927

that I last saw h[illegible] alive on July 18, 1927

and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

hypertension, chronic? acute, hypertensive nephritis, uremia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Sub

(Signed) C. Wilmer Boyd M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Blks.

E 24148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 24148

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St., 18-16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Ransom

(a) RESIDENCE NO. 923 Price St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 35 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O.H.D.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Ransom

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant

(Address) [redacted] Lucido

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1927, to Jan 18, 1927, that I last saw h alive on Jan 18, 1927, and that death occurred, on the date stated above, at 2:20 A. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

Myocardial insufficiency

Syphilis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Symptoms

(Signed) C. Wilmer Brown, M. D.

19 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial , 19

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

BALTIMORE CITY HOSPITALS

C. Hampson, M.D.

JAN 21 1927

1366

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24149

40 E 24149

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jordan

(a) RESIDENCE NO. 7 W York St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE: Years 59 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer): 74

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Wm Jordan

11 BIRTHPLACE OF FATHER (City or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Eliza

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant .....

(Address) .....

15 Filed ....., 19 ..... RRR Registrar

1557 Cremated

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

7-17-27

17 I HEREBY CERTIFY, That I attended deceased from 7-7-, 1927 to 7-17-, 1927

that I last saw h[illegible]live on 7-17-, 1927

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Lateral Sclerosis and Chronic Extraordinaria Pernicious Sclerosis, Pernicious and Abdominal Wall (duration) 1 yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 7-7-27

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) [signature], M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24150

CERTIFICATE OF DEATH.

+ 179

E 24150

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp 11-24 St., Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph McNeil

(a) RESIDENCE NO. 612 (B) St. (Sparrows Point) St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1904

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith's helper

(b) General nature of industry, business, or establishment in which employed (or employer) Steel

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town) _____

(State or country) Nova Scotia

PARENTS

10 NAME OF FATHER Angus McNeil

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) N.S.

12 MAIDEN NAME OF MOTHER Doyle

13 BIRTHPLACE OF MOTHER (city or town) Sydney Mines

(State or country) N.S.

14 Informant John McDonald

(Address) 612 (B) Sparrows Point

15 Filed _____, 19____ _____ Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd. degree burns of body (accidental)

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Coke oven explosion

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. C. Hemmeter M. D.
(Coroner)

19 27 (Address) 2502 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sydney Mines Nova Scotia Date of Burial 7/22/1927

20 UNDERTAKER J. J. Moran ADDRESS 300 E. Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2 1927 C. HARRISON JONES, M. D.

Registrar

Per repd

Spec.–7-17-26—A Co.—200 Bks.

D 24151 (47 9 6)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 24151

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elvis Seymour

(a) RESIDENCE NO. 1044 S-Hanover St. Ward City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 8-14-26

7 AGE — Years: 11 — Months: — Days: 7 — IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER: Wm. Seymour

11 BIRTHPLACE OF FATHER (City or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Ruth Wagner

13 BIRTHPLACE OF MOTHER (city or town): Pa.
(State or country)

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. 19
Per R.R.R. Registrar

22 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1927

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1927, to July 21, 1927, that I last saw her alive on July 21, 1927, and that death occurred, on the date stated above, at 12 — m.

The CAUSE OF DEATH* was as follows:

acute gastro-intestinal indigestion with high fever

3 weeks (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted
If not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) H. Geraghty, M. D.
, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A A Co — Date of Burial: July 25 1927

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24152

CERTIFICATE OF DEATH

161-002 E 24152

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1046 Falls Road St. 13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Haines Jr.

(a) RESIDENCE NO. 1046 Falls Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7, 1927

7 AGE Years: 0 Months: 0 Days: 15 14

IF LESS than 1 day 8 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto,

(State or country) Md.

PARENTS

10 NAME OF FATHER Morris Haines

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Mary R. Brothers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carroll Co. Md.

14 Informant Mary R. Haines

(Address) 1046 Falls Road

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 7, 19 27, to July 22, 19 27, that I last saw h[illegible] alive on July 21, 19 27, and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows:

Respiratory Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No (Gross and Microscopic)

What test confirmed diagnosis? Physical Signs

(Signed) J. H. Wade, M. D.

7/22, 1927. (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial July 23, 1927.

20 UNDERTAKER J. Walter Davis ADDRESS 3307 Paine St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

E 24153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24153

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Univ Hosp. St., 425 (Ward) 24-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T Russell

(a) RESIDENCE NO. 816 Liberty St. Ward

(Usual place of abode.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
Unknown 1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Lunchroom

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New Hampshire

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Chas W Lauer

(Address) 8 N Liberty St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 6 hrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 1 yrs. 0 mos. 1 ds.

July 27/27 (Signed) C C Yates M. D.

19 (Coroner) (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Plattsburg New Hampshire Date of Burial July 27 1927

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2 1927 C. HAMPSON JONES M. D.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24154

CERTIFICATE OF DEATH

129

E 24154

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3623 Fairview Ave (or 45-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hood

(a) RESIDENCE NO. 3623 Fairview Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary F. Hood

6 DATE OF BIRTH (month, day, and year): 4/15/1845

7 AGE — Years: 82 Months: 3 Days: 6 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Johana Hood

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Matilda Haughley

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant Mrs. W. E. Jones

(Address) 3623 Fairview Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to July 21, 1927, that I last saw him alive on July 20, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chron Nephritis Advanced

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arthma

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Slipped Sunday

(Signed) Herbert E. Seeps, M. D.

19 (Address) 3048 N. Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem. — Date of Burial: July 23 27

20 UNDERTAKER: Margaret J. Flynn — ADDRESS: 14 W. Eight St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 27 1927 C. HARRISON JONES, M.D.

Registrar

N.A.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24155

E 24155

CERTIFICATE OF DEATH.

REGISTERED NO. 144

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. ~~1730~~ 2230 7 Fleet ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mazerska

(a) RESIDENCE. No. 2230 7 Fleet ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Married

5a If married, widowed, or divorced (or) WIFE of Vincent Mazerska

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ~ hrs. or ~ min.
30		0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Unknown Grotka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Grotka.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Vincent Mazerski

(Address) 2230 Fleet St

15 Filed ——— 19 ——— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to July 21, 1927, that I last saw h alive on July 21, 1927, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Post portum hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atony of uterus.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Chas. S. Leonhardt, M. D.

19 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 25 19 27
20 UNDERTAKER	ADDRESS
John W. Weber	1803 Bank

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

(Grausee)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 24156

CERTIFICATE OF DEATH. X 65-001

E 24156

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Balt Gen 24 St. 33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Grausee

(a) RESIDENCE NO. Lutheran Heights St. Ward Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. days How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 30 1925

7 AGE: Years 2 Months 5 Days 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer a

9 BIRTHPLACE (city or town):

(State or country) a a Co md

PARENTS

10 NAME OF FATHER Henry J Grausee

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Sarah Schafer

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Harford Co Md

14 Informant Mrs Henry J Grausee

(Address) Lutherglen Heights

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 21 1927

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to July 21, 1927,

that I last saw her alive on July 21, 1927,

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Myelogenous Leukemia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Gastro Enteritis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Lutheran Heights

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Picture

(Signed) William W. Edmunds, M. D.

, 19 (Address) S Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dorsey Date of Burial Perkins M E Cem Md July 23 1927

20 UNDERTAKER John O Mitchell Sons Cem ADDRESS 19 Eutaw Place

OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 24 1927 C. HAMPSON JONES, M.D. Registrar

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24157 45 E 24157

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2306 N Charles St. 12-50 Ward)

2-FULL NAME Ann Casey Elledge

(a) RESIDENCE NO. 2306 N. Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edw. E. Elledge

6 DATE OF BIRTH (month, day, and year): Sept 4 - 1876

7 AGE — Years: 50 | Months: 10 | Days: 17 | If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER: John T. Casey

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ireland

12 MAIDEN NAME OF MOTHER: Mary Jane Gunn

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Virginia

14 Informant: Miriam Elledge

(Address) 2400 N. Charles St

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1927

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1927, to July 21, 1927, that I last saw h.. alive on July 20, 1927, and that death occurred, on the date stated above, at 10½ A.M.

The CAUSE OF DEATH* was as follows:

Malignant Epidermoid Cystoma

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of May 3rd 1926

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) [illegible] M. D.

7-22-1927 (Address) 1127 Mercantile Trust Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial 7/23 1927

20 UNDERTAKER: Chas. F. Grace & Son ADDRESS 118 W. Mt. Royal Ave

OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

7-22-1927 [illegible]

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24158

CERTIFICATE OF DEATH.

90 E 24158

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp. 16-23 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas M. Brooks

(a) RESIDENCE NO. 709 N. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence E. Brooks

6 DATE OF BIRTH (month, day, and year): About 1881

7 AGE: Years 46 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): Gen'l

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER Benj. Brooks

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Susie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant: Mrs. Thos. M. Brooks

(Address) 709 N. Carey St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Tennery M. D.

(Coroner)

June 27, 1927 (Address) 250 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial July 23 1927

20 UNDERTAKER: John H. Toadvine ADDRESS 1027 Druid Hill Ave

JUL 21 1927 C. H. WILSON, Local Reg. M. D.

Be sure that every item is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24159

CERTIFICATE OF DEATH.

31 E 24159

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 502 N. Glover St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albina Wagner

(a) RESIDENCE NO. 804 N Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Morton Wagner

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years 22; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Frank Krumb

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Josephine Lechte

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto

14 Informant: Frank Krumb

(Address): 804 N Castle St

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 2 19 27, to July 21, 19 27, that I last saw her alive on July 31 19 27, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? .....

(Signed) Louis Krause, M. D.

, 19 (Address) 2500 E. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. Date of Burial July 23 1927

20 UNDERTAKER: Frank Erickson ADDRESS 1906 Woodb

C. HERBERT JONES, M. D.

JUL 23 1927

Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400. Bks.

E 24160

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24160

CERTIFICATE OF DEATH.

X 124

1-PLACE OF DEATH

City of BALTIMORE: (No. 126 W. Glen ave. St., Parkwood Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta N. Witt

(a) Residence No. Dieter ave. Stemmers Run Md. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of August L. Witt

6-DATE OF BIRTH (month, day and year) May 24th 1859

7-AGE. 68 yrs. 1 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Tamerminde Germany

PARENTS.

10-NAME OF FATHER Frederick Levine

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Tamerminde Germany

12-MAIDEN NAME OF MOTHER Dorthea Fink

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Tamerminde Germany

14- (Informant) August L. Witt

(Address) Stemmers Run Md.

15-

Filed ..... 192.....

Registrar.

instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 21st 27

17- I HEREBY CERTIFY, That I attended deceased from July 16 1927 to July 21 1927

that I last saw h.. alive on July 21st 1927

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Esther B. Benson M. D

7/22/1927 (Address) Dundalk Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Parkwood Cemetery	July 24 1927
20-UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24161

CERTIFICATE OF DEATH.

84 E 24161

REGISTERED NO._____

1-PLACE OF DEATH
City of BALTIMORE: (No. Pronounced dead at the South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Lidsay McCuen.

(a) RESIDENCE NO. 311 Warren Ave, St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) April 16, 1865.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Traveling salesman.
(b) General nature of industry, business, or establishment in which employed (or employer) Swondell Bros.
(c) Name of employer Glass Co.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Adam McCuen.
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.
12 MAIDEN NAME OF MOTHER Anna B. Watson.
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Anna B. M. McCuen. (sister)
(Address) 311 Warren Ave.

15 Filed _____ 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 192 7.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) did that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

7/22 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Date of Burial 7/23 1927

20 UNDERTAKER W. J. Ficker Son ADDRESS E. Balto.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

23 1927 C. HAMILTON JONES, M. D.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24162

CERTIFICATE OF DEATH

118 E 24162

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St. Joseph Hospital St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Augusta Stein

(a) RESIDENCE NO. 8 N. Ann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Stein

6 DATE OF BIRTH (month, day, and year): Oct. — 1860.

7 AGE: 66 Years 47 Months 10 Days —

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of indostry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: William Apsor.

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rose —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Thomas Stein

(Address): 8 N. Ann St.

15 Filed ..... 19 .....

C. HAMILTON JONES, M. D.

Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 22 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to July 22, 1927,

that I last saw her alive on July 22, 1927,

and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Ventricular Fibrillation

(Strangulated)

(duration) 18 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-21-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Laurence Fahrney, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary.

Date of Burial: July 25. 1927.

20 UNDERTAKER: M. J. Sadowski

ADDRESS: 705 S. Ann

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

23 1927

Spec.—1-10-21—M&T—1500 Bks.

(Cegielska)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24163

CERTIFICATE OF DEATH.

46 E 24163

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 S. Wolf ST. 2-4 WARD)

2-FULL NAME Victoria Cegielska

(a) RESIDENCE NO. 703 S. Wolf ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Cegielski

6 DATE OF BIRTH (month, day, and year)

7 AGE: 51 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jacob Kendzierski

11 BIRTHPLACE OF FATHER (city or town) (State or country): German Poland

12 MAIDEN NAME OF MOTHER: Agnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): German Poland

14 Informant: Mrs Eva Zawadzki

(Address): 703 S. Wolf St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1927

17 I HEREBY CERTIFY, That I attended deceased from November 26, 1926, to July 22, 1927,

that I last saw her alive on July 22, 1927

and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Uterus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uterine Hemorrhage

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Exam

(Signed) C. Chmielewski, M. D.

July 27, 1927 (Address) 2042 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus

DATE OF BURIAL: July 26, 1927

20 UNDERTAKER: M. J. Sadowski

ADDRESS: 703 S. Wolf St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

JUL 25 1927 C. HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24164

CERTIFICATE OF DEATH.

90 E 24164

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2406 Shirley Ave 15-58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard M. Shaffer.

(a) RESIDENCE NO. 2406 Shirley Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A. Shaffer.

6 DATE OF BIRTH (month, day, and year) July 30th 1850

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	76	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Physician)

(b) General nature of industry, business, or establishment in which employed (or employer) Machine Shop.

(c) Name of employer Aurora.

9 BIRTHPLACE (city or town) W. Va.

(State or country)

PARENTS

10 NAME OF FATHER Jas. H. Shaffer

11 BIRTHPLACE OF FATHER (city or town) W. Va.

(State or country)

12 MAIDEN NAME OF MOTHER Cordelia Wotring

13 BIRTHPLACE OF MOTHER (city or town) W. Va.

(State or country)

14 Informant Chas. A. Shaffer

(Address) 2406 Shirley Ave

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

23 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 1. 1927, to July 22, 1927

that I last saw h— alive on July 21. 1927

and that death occurred, on the date stated above, at 4-30 a. m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(duration) .....yrs. 12 mos. .....ds.

Is Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms only

(Signed) W. B. Peacock, M. D.

, 19 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial July 25 1927

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. Fayette ave

Be sure the Physician fills out the Medical Certificate of Death, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

E 24165

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 24165

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] Ward) 4-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Galloway

(a) RESIDENCE NO. 416 N. Greene St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1863.

7 AGE Years: 64 Months: Days: IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory work.

(b) General nature of industry, business, or establishment in which employed (or employer): Box maker

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant BALTIMORE CITY HOSPITALS [redacted]

(Address) [redacted]

15 Filed ..... 19 .....

Registrar

23 1927

RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/21/1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1925, to July 21, 1927

that I last saw her alive on July 21, 1927

and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

arteriosclerosis

Hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ?

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Sect.

(Signed) C. Sutherland Boyd, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Ave

Date of Burial: July 23 1927

20 UNDERTAKER: Joseph Cook

ADDRESS: 1031 N. Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 24166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124 E 24166

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1166 Washington Blvd. St. 21-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Brunn

(a) RESIDENCE NO. 1166 Washington Blvd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Brunn

6 DATE OF BIRTH (month, day, and year): June 22, 1851

7 AGE: Years 75 Months Days 29 IF LESS than 1 day hrs. or min.. 30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Snyder

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant Mrs Jane Hannan

(Address) 1526 N. Fulton Avenue

15 Filed 7-23 1927 19 C. Harrison Jones M.D. Registrar

Per RKA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1927, to July 21st, 1927, that I last saw her alive on July 21st, 1927, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Chronic hypocarditis,

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY Chron's Interstitial Nephritis.

(Secondary)

(duration) 1 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? — No —

What test confirmed diagnosis? Clinical + Urinalysis

(Signed) William J. Sullivan, M. D.

7/22, 1927 (Address) 1701 N. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial 7/23 1927

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—K. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24167

CERTIFICATE OF DEATH.

E 24167

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2101 N Pulaski St. 15-5 Ward)

REGISTERED NO. 15-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernhardt Fischer

(a) RESIDENCE. No. 2101 N. Pulaski St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fena Fischer

6 DATE OF BIRTH (month, day, and year): May 27 1860

7 AGE: Years 67 Months 1 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Fena Fischer 2101 N Pulaski St

15 Filed 25 1927, 19 C. EMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 21 July 1927

17 I HEREBY CERTIFY, That I attended deceased from 20 July, 1927, to 21 July, 1927, that I last saw him alive on 21 July 1927 and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of throat

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinomatosis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1926

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic exam of tissue

(Signed) Vincent Hooper, M. D.

, 19 (Address) 2060 Ford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: July 25 1927

20 UNDERTAKER: F. B. Wilfert

ADDRESS: 1850 N. Paulo St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24168

CERTIFICATE OF DEATH.

E 24168

REGISTERED NO. 74001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2712 St. Paul St. (Ward) 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James McNaney

(a) RESIDENCE NO. 2712 St. Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. McNaney

6 DATE OF BIRTH (month, day, and year) Oct 1 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

016

9 BIRTHPLACE (city or town) (State or country) W. Virginia

PARENTS

10 NAME OF FATHER John McNaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Virginia

12 MAIDEN NAME OF MOTHER Mary Barns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Miss Bertha McNaney

(Address) 2712 St. Paul St.

15 Filed July 25, 1927 Registrar R of D

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to July 22, 1927, that I last saw him alive on July 22, 1927, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy - Cerebral - Hemorrage

(duration) Sudden — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Infirmities of age - possibly

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. M. Barnbaker, M. D.

, 19 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bello Cemetery DATE OF BURIAL July 25 1927

20 UNDERTAKER W. Hamner Preston ADDRESS Eutaw

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 24169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 24169

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 239 S Wallace St. 3-4 WARD)

2-FULL NAME James Saunders

(a) RESIDENCE NO. 239 S Wallace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married.

5a If married, widowed, or divorced (~~HUSBAND of~~ or) WIFE of Rosie Saunders

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va Norfolk.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Sarah Newton (friend)

(Address) 2340 Mullins st.

15 Filed , 19 Registrar

C. HAMPSON JONES, M. D.

7-23-1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to July 19, 1927, that I last saw h alive on July 16, 1927, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Thoracic Aneurism

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Liver

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes (at city morgue)

What test confirmed diagnosis? Clinical

(Signed) R T Young M. D.

7/25 1927 (Address) Hoy & Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem DATE OF BURIAL July 23 1927.

20 UNDERTAKER Wendell J. Hippe ADDRESS 2000 Eastern

ATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24170

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) W. Balto General Hospital (WARD)

REGISTERED NO. 27552

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith J. Atkins

(a) RESIDENCE NO. 422 W. Hayward Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yr. 6 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 16, 1926

7 AGE: Years | Months: 7 | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Clarence Atkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Ruth Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Hospital Records (Address)

15 Filed 2 3 1927, 19 Past

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1927

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1927, to July 21, 1927

that I last saw her alive on July 21, 1927

and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH was as follows:

Acute Encephalitis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam

(Signed) Louis T. Levy, M. D.

7-24, 1927 (Address) W. Balto Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Bridge Md. DATE OF BURIAL: July 24 1927

20 UNDERTAKER: Harry A. Witzke ADDRESS: 553 W. Lombard St

IRON is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

002

10 E 24171

E 24171

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp. ST., 15-21 WARD)

2-FULL NAME Rose Katz

(a) RESIDENCE NO. 1524 Presbury St. WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 15 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	3	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Max Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta Fax

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Max Katz 1524 Presbury St.

15 Filed 7-24 1927 Per RRL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-22-27, 19 , to 7-24-27, 19 ,
that I last saw he alive on 7-24-27, 19
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:
Tonsilar Diphtheria

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Laboratory
(Signed) Myron G. Tull M. D.
, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Orth. Cathol. Bur. DATE OF BURIAL 7-24 1927

UNDERTAKER Jack Levin ADDRESS 1439 E Balto

TION is very important. See instructions on back of certificates.

C. HAMILTON JONES, M. D.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24172 PLACE OF DEATH

REGISTERED NO. C 23 E 24172

CITY OF BALTIMORE (No. 521 Chestnut Hill ave St. 9-47 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Edward Graham

(Residence in Baltimore: No. 521 Chestnut Hill ave St.: 75 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: January (Month) 8th (Day), 1844 (Year)

7 AGE: 83 yrs. 6 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Coal Dealer

9 BIRTHPLACE (State or country): Aberdeen, Scotland

PARENTS

10 NAME OF FATHER: John Graham

11 BIRTHPLACE OF FATHER (State or country): Inverness, Scotland

12 MAIDEN NAME OF MOTHER: Margaret Ingles

13 BIRTHPLACE OF MOTHER (State or country): Peterhead Scotland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert L Graham

(Address) 521 Chestnut Hill ave

15. Filed JUL 24 1927 C. HAMPSON JONES, M. D. Per RH REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 23 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to July 23 1927, that I saw h-- alive on July 22, 1927, and that death occurred, on the date stated above, at 1-45 p. m. The CAUSE OF DEATH* was as follows:

Paraplegia " Atopic"

(Duration) yrs. mos. 7 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) H. L. Prentiss M. D.

July 23, 1927 (Address) 634 Gorsuch Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: July 25th 1927

20 UNDERTAKER: George E Welling & Sons — ADDRESS: 1126 E Monument St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Dr Pettibone, 814 Hamilton Terrace

E 24173

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 250 N. Biddle ST. 11-24 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Gray.

(a) RESIDENCE No. 250 N. Biddle ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Gray

6 DATE OF BIRTH (month, day, and year) June 6, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs Jenkins

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Millie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Kate Gray (Address) 250 N. Biddle St

15 Filed JUL 24 1927 H. [illegible] Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1927

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1927, to July 22, 1927, that I last saw him alive on July 22, 1927 and that death occurred, on the date stated above, at 6 P. m

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. — mos. 3 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. M. C. Pettibone, M. D.

, 19 (Address) 814 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL July 25 1927

20 UNDERTAKER J. W. Cook — ADDRESS 502 E. Madison

Spec.—1-10-21—M&T—1500 Bks.

E 24174 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 E 24174

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1914 Payson ST. 15-21 WARD)

2-FULL NAME George W Mally

(a) RESIDENCE NO. 1914 Payson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Elizabeth Mally

6 DATE OF BIRTH (month, day, and year): Oct 11th 1857

7 AGE: Years 69 | Months 9 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Coal engineer

(c) Name of employer: National Biscuit Co.

9 BIRTHPLACE (city or town) (State or country): Harford Co Md

PARENTS

10 NAME OF FATHER: Richard Mally

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Moran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Mary Mally

(Address) 1914 Payson St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1927

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1927, to July 22 1927, that I last saw h[illegible] alive on July 22 1927, and that death occurred, on the date stated above, at 5[illegible] PM.

The CAUSE OF DEATH* was as follows:

Heat exhaustion

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Nephritis unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald F Longy M. D.

, 19 (Address) 414 E Monte Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: 7/25 1927

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

95386 E 24175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 24175

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Brooks

(a) RESIDENCE NO. 1322 Penn Ave St. Ward Calv

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER John Brooks

11 BIRTHPLACE OF FATHER (City or town) Md —
(State or country)

12 MAIDEN NAME OF MOTHER Martha Wallace

13 BIRTHPLACE OF MOTHER (city or town) Md —
(State or country)

14 Informant Records —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June 13. 1927. to July 22. 1927.

(that I last saw h.. alive on July 22, 1927.

and that death occurred, on the date stated above, at 2 30 a- m.

The CAUSE OF DEATH* was as follows:

Aneurism of thoracic aorta
obstructing trachea

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann & X-ray

(Signed) E. Fowler Andrus, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park	7, 24 1927
20 UNDERTAKER John D Stevens	ADDRESS 4-1-C N Lanvale St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24176

CERTIFICATE OF DEATH

129 E 24176

1-PLACE OF DEATH

City of BALTIMORE: (No. 4103 Bateman Avenue St. 1575 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Bernhard

(a) RESIDENCE NO. 4103 Bateman Avenue St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeanette Bernhard

6 DATE OF BIRTH (month, day, and year) March 11, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	70	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Church Sexton

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Germany

PARENTS

10 NAME OF FATHER Casper Bernhard

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Paush

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

14 Informant H. C. Bernhard

(Address) 4103 Bateman Avenue

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,

that I last saw him alive on ....., 19...,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Heart Disease

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic Nephritis

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. D. Mayer M. D.

July 25 19 27 (Address) 1520 E. 33rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — Date of Burial 7/25/27

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 W Baltimore St

JUL 27 1927 C. HARRISON JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

D 24177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 24177

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Wilson

(a) RESIDENCE NO. 1728 McCubbin St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md,

PARENTS

10 NAME OF FATHER Karl Gorman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Hopkins Hospital

(Address)

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

July 22/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rt. Lobular Pneumonia—Pleurisy

(Autopsy at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) [signature] M. D.

(Coroner)

7/24/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

ad Bury Cemetery July 1927

20 UNDERTAKER ADDRESS 1631 Orleans St

Edward Bryan

Or death in penal institutions, or in any of the public institutions. Fill out all parts. See instructions on back of certificate. Every statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24178 — CERTIFICATE OF DEATH. — 44 E 24178

1-PLACE OF DEATH 935 Rutland ave

CITY OF BALTIMORE: (No. ... ST., 19 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Mitchell

(a) RESIDENCE No. 935 Rutland Ave ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Mitchell

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 64 | Months | Days | If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mary Mitchell
(Address) 935 Rutland ave

15 Filed JUL 25 1927, 19 ... E. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-10-27, 19 ... to 7-23-, 19 27, that I last saw h— alive on 7-22 1927, and that death occurred, on the date stated above, at 6 20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
acute Cardiac failure

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W. B. Butler ... M. D.

19 (Address) 925 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery — DATE OF BURIAL: July 27 1927

20 UNDERTAKER: Edward Bryan — ADDRESS: 1681 Orleans st

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 24179

E 24179

CERTIFICATE OF DEATH

REGISTERED NO. .....

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. ..... St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Rehmann

(a) RESIDENCE NO. 226 Duncan alley Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records.

15 Filed JUL 25 1927 16 C. HAMPSON JONES M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/23/1927

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to July 23, 1927, that I last saw h. alive on July 23, 1927 and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

myocarditis, chronic - acute
hypostasis
cardiac arrest

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Gunerud's Test

(Signed) C. Hampson Jones M. D.

Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery — Date of Burial July 26 1927

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24180

E 24180

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee C. Bennett

(a) RESIDENCE NO. Lakeside Rd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 24, 1844

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Cigars

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. A. Bennett

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Hattie Featherwood

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Geo. A. Bennett

(Address) Lakeside 7M.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry.)

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

For a number of years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Md. Date of Burial July 6 1927

20 UNDERTAKER Veirs & Son, Inc. ADDRESS Lakeside

very important. See instructions on back of certificate.

OF DEATH in plain terms, so that it may be properly

C. HAMILTON JONES, M.

DEC 29 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 24181

CERTIFICATE OF DEATH.

E 24181

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1203 Warner St. 21-31 Ward)

2-FULL NAME John Heim

(a) RESIDENCE NO. 1203 Warner St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. __ mos. __ ds. How long in U. S., if of foreign birth? __ yrs. __ mos. __ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 13th 1876

7 AGE: Years 50 | Months 11 | Days 14 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Heim

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Koch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Jane Heim
(Address) 1203 Warner

15 Filed JUL 25 1927 C. HAMPSON JONES, M. D., Registrar
Per R K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1927

17 I HEREBY CERTIFY, That I attended deceased from July 20 1927, to July 24, 1927, that I last saw h— alive on July 24, 1927, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinically

(Signed) A. K. Campbell M. D.
July 24, 1927 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. Date of Burial: July 27 1927

20 UNDERTAKER: Eschenauer Funeral Home ADDRESS 937

Be sure all items are answered, or state that no answer is known. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24182

CERTIFICATE OF DEATH.

127-001

E 24182

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2300 Washington ST. 10-14 (WARD)

2-FULL NAME Walter D. Cursey,

(a) RESIDENCE NO. 1121½ Argyle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Norah Cursey

6 DATE OF BIRTH (month, day, and year): May 23, 1887

7 AGE: Years 40 Months 1 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: David Cursey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md.

12 MAIDEN NAME OF MOTHER: Mary Amin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md.

14 Informant: Wife (Mrs Norah E. Cursey)

(Address) 2300 Washington Boulevard

15 Filed JUL 25 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1927

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to July 22, 1927, that I last saw him alive on July 22, 1927, and that death occurred, on the date stated above, at 6.20 p.m.

The CAUSE OF DEATH* was as follows:

Portal Cirrhosis.

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm. A. Stevens, M. D.

19 (Address) 120 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 7/26, 1927

20 UNDERTAKER: Henry W. Peters & Son — ADDRESS: 505 N. Calvert

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24183

REGISTERED NO. 90 E 24183

E 24183
1-PLACE OF DEATH

City of BALTIMORE: (No. 1605-Eutaw Place. St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Popplein

(a) RESIDENCE NO. 1605-Eutaw Place St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 11 mos. 2 ds. How long in U. S. if of foreign birth? 83 yrs. 11 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (single)

6 DATE OF BIRTH (month, day, and year) August-20-1843

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	83	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paint Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) Paints

(c) Name of employer Popplein Paint Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Popplein

11 BIRTHPLACE OF FATHER (City or town) Frankfurt

(State or country) Germany

12 MAIDEN NAME OF MOTHER Susannah Thomson

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant Mrs. Laura I. Ricketts, (sister)

(Address) 1605-Eutaw Place, City.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-22- 1926 to 7-22 1927

that I last saw h[illegible] alive on 7-22 1927

and that death occurred, on the date stated above, at 9. P. m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis with Hypertension Chronic myocarditis - Uraemic Cystitis.

(duration) ? yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Renal insufficiency -

(duration) ... yrs. 2 mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Lemarco, M. D.

7-23. 1927 (Address) 1604 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
GreenMount Cemetery	July-25-1927
20 UNDERTAKER STEUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

JUL 25 1927 C. HAMPSON, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24184

CERTIFICATE OF DEATH.

E 24184

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 718 Appleton ST. 16-22 (WARD) 23

2-FULL NAME Georgia A. Knight

(a) RESIDENCE NO. 718 Appleton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced—HUSBAND of (or) WIFE of: John W. Knight

6 DATE OF BIRTH (month, day, and year): June 16, 1867

7 AGE: Years 60 Months 1 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thos J. Garrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Wm Bustraan

(Address) 718 Appleton St

15 Filed JUL 25 1927 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to July 24, 1927, that I last saw h[illegible] alive on July 23, 1927 and that death occurred, on the date stated above, at 8.05 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Gall-bladder Operation

(duration) yrs. 1 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/6/27

Was there an autopsy? Yes Removal of Gall Stone

What test confirmed diagnosis?

(Signed) [illegible] M. D.

July 25, 1927 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: July 26 1927

20 UNDERTAKER: [illegible] Jackson Ave

ADDRESS: Balto

INSTRUCTION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24185

E 24185

31

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St., 13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Cross

(a) RESIDENCE NO. 1221 Dellwood Ave Hampton, Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER William E. Cross

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Kizarh Neal

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7, 19 27, to July 23, 19 27,

that I last saw him alive on July 23, 19 27,

and that death occurred, on the date stated above, at 4.15 a. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY Tuberculosis

(Secondary)

Laryngitis (duration) 1 yrs. mos. ds.

18 Where was disease contracted Unknown

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) C. Holmes Bond M. D.

7-23- 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Natural Balto Md July 26 1927

20 UNDERTAKER — ADDRESS

A. L. Burgee, Per C. Harper 3637 Falls Rd.

...ion should be entirely supplied. Avoid abbreviations. The cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24186

E 24186

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 N. Chapel ST., WARD)

2-FULL NAME Ferdinand Miller

(a) RESIDENCE NO. 1617 N. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Singe

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/24/1926

7 AGE Years	Months	Days	If LESS than 1 day: hrs or min
—	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John A. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Rusty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) John A. Miller 1617 N. Chapel st

15 Filed ..., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 - 1927

17

I HEREBY CERTIFY, That I attended deceased from July 5 - 1927 to July 24 1927.

that I last saw him alive on " 23 1927

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) — yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

7/24/1927 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rueben Cemty. DATE OF BURIAL July 25 1927

20 UNDERTAKER George H. Rusty ADDRESS 735 Harford Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24187

CERTIFICATE OF DEATH.

57

E 24187

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Ellis

(a) RESIDENCE NO. 2410 Madison Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Ellis

6 DATE OF BIRTH (month, day and year): 1882

7 AGE: Years 45 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Benj Bear

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Russia

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Russia

14 Informant: Harry Ellis

(Address): 2410 Madison Ave

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24. 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes

Duration

CONTRIBUTORY (Secondary)

Duration

Signed: M. D.

(Coroner)

July 25, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Home Rd Date of Burial: July 25 1927

20 UNDERTAKER: Jack Levin ADDRESS

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24188

CERTIFICATE OF DEATH.

31 ✓ **E 24188**

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 611 Pat Pk Ave St., 3 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C. Sommers

(a) RESIDENCE NO. 611 Pat Pk St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 21st 1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
34	35	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Benjamin Sommers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Amelia G. Wiley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Amelia G. Sommers

(Address) 611 S. Patterson Park Ave

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pub. T. B.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Colon

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

24 W (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mount Carmel Cem. July 25 1927

20 UNDERTAKER — ADDRESS

Lilly & Zeiler — 403 S. Holyd St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 24189

CERTIFICATE OF DEATH.

E 24189

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 713 Ward)

2-FULL NAME Jack Thomas

(a) RESIDENCE NO. 1631 Milliman St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Santuc, S.C.

PARENTS

10 NAME OF FATHER Clarence Thomas

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Ida Snowden

(Address) 1708 E. Madison St

15 Filed JUL 25 1927 19 Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage-Aneurism of cerebral arteries, Probably congenital malformation. (Autopsy at Hopkins) (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Weller M. D.

(Coroner)

7/23 19 27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Ashburn Cemetery July 25 1927

20 UNDERTAKER ADDRESS

Ida Snowden 1708 E. Madison St

Very important. See instructions on back of certificate. Fill in all items, and if any are unknown, state the fact. Early statement of occupation is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24190

1-PLACE OF DEATH

•CERTIFICATE OF DEATH

5

E 24190

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence G. Winter

(a) RESIDENCE NO. 2405 Wash. Blvd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 11 mos. 23 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29th 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	28	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country) Md

PARENTS

10 NAME OF FATHER Christian Winter

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Maggie Lock

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Christian Winter Jr

(Address) 2405 Wash Blvd

15 Filed ....., 19.... Registrar

DEC 25 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

7/22/27

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927 to July 22, 1927, that I last saw him alive on July 22, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Postencephalitic Parkinsonian syndrome - for several years

Pertussis malignis - Terminal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) F. F. Lusby, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Park — Date of Burial 7/26 1927

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson

(If DEATH in plain terms, so that it may be properly classified. Last Statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.—7-17-26—A Co.—200 Bks.

E 24191

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24191

CERTIFICATE OF DEATH

31

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Bradbury

(a) RESIDENCE NO. 517 S. East ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Grace Bradbury

6 DATE OF BIRTH (month, day, and year) Dec 15 1875

7 AGE	Years	Months	Days
	51	4	10

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER John Bradbury

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

JUL 25 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 July 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1927, to July 24, 1927, that I last saw him alive on July 24, 1927, and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Tuberculous meningitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry C. Smith, M. D.

7-24-1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial July 28 1927

20 UNDERTAKER George W. Zibler — ADDRESS 1757 E. Eager st

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 24192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

119 ✓ E 24192

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 507 N. Carey St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Thompson

(a) RESIDENCE NO. 507 N. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colord

5 Single, Married, Widowed, or Divorced. (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 1924

7 AGE: Years 2 Months 7 Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER W. C. Thompson

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Ethel Williams

13 BIRTHPLACE OF MOTHER (city or town) S. C.

(State or country)

14 Informant Ethel Williams

(Address) 507 W. Carey St.

15 Filed 19 Registrar

Per

JUL 25 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1927

17 I HEREBY CERTIFY, That I attended deceased from July 17 1927 to July 22 1927

that I last saw h alive on I

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Burns Thigh Degree

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Pain Shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Exatelin, M. D.

7/24 1927 (Address) 1215 Pa Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — Date of Burial: July 25 1927

20 UNDERTAKER: Edward Bryan — ADDRESS: 1631 orleans St

C. HAMPSON JONES, M. D.

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24193

CERTIFICATE OF DEATH.

31

E 24193
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 N. Dallas ST. 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ola Mims

(a) RESIDENCE NO. 1702 N. Dallas ST. 8th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Haywood Mims

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Ira Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Laura Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant: Haywood Mims

(Address) 1702 N. Dallas st.

15 Filed JUL 25 1927 C. HANSON JONES, M. D. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 - 1927

17

I HEREBY CERTIFY, That I attended deceased from July 13 - 1927, to July 22 - 1927, that I last saw her alive on July 18 - 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin H. Fenby M. D.

1927 (Address) 1223 N. Carolina st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL July 25 1927

20 UNDERTAKER Mrs J. S. Locke

ADDRESS 802 Jefferson

TION is very important. See instructions on back of certificates.

Spec.--7-17-26—A Co.—200 Blks.

20495-3 E 24194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

×90

E 24194

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 94 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Heineman

(a) RESIDENCE NO. 211 Main St. St. Ward Charlestown N.H.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-6-50

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	77		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10 NAME OF FATHER Abraham Heineman

11 BIRTHPLACE OF FATHER (City or town)
(State or country) France

12 MAIDEN NAME OF MOTHER Leah Frank

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) France

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
July 25 1927

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1927, to July 25, 1927, that I last saw h[im] alive on July 25, 1927, and that death occurred, on the date stated above, at 705 A m.

The CAUSE OF DEATH* was as follows:

myocardial failure
following prostatectomy
Operation. Benign Prostatic Hypertrophy
(duration) 3 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) ~~Stenosis pyelitis~~ Chronic Myocarditis
(duration) 10 yrs. mos. 3 ds.

18 Where was disease contracted ~~if not at place of death~~?

Did an operation precede death? Yes Date of July 22, 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Robertson, M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamestown N.Y. Date of Burial July 25 1927

20 UNDERTAKER John O Mitchell ADDRESS 1900 Eutaw Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24195 — 1-PLACE OF DEATH

E 24195 — REGISTERED NO.

City of BALTIMORE: (No. 1752 E Preston St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen E. Stakeland

(a) RESIDENCE NO. 1752 E. Preston St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 3 mos. 16 ds. How long in U. S. if of foreign birth Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Thomas R. Stakeland

6 DATE OF BIRTH (month, day and year): April 7 1861

7 AGE — Years: 66 — Months: 3 — Days: 16 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto (State or country) Md

PARENTS

10 NAME OF FATHER: William L. Davis

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. Thomas R. Stakeland

(Address): 1752 E Preston St

15 Filed JUL 25 1927 19 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 19 27

17 I HEREBY CERTIFY, That I attended deceased from March 22 19 27 to July 22 19 27

that I last saw h[illegible] alive on July 22 19 27

and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

General Degeneration with Hypostatic Pneumonia

(duration) 4 yrs. 4 mos. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis + Paralysis agitans

(duration) 4 yrs. 7 mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Decker M. D.

7/24 19 27 (Address) 928 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: July 26 1927

20 UNDERTAKER: Henry Kreck & Sons — ADDRESS: 1301 E Eager

IF DEATH IS FROM VIOLENCE, STATE WHETHER IT MAY BE PROPERLY CLASSIFIED AS ACCIDENT, SUICIDE OR HOMICIDE. LATER STATEMENT OF OCCUPATION IS very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24196

CERTIFICATE OF DEATH.

90 ✓

E 24196
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Tripp

(a) RESIDENCE NO. 1936 Brunt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER: Solomon Tripp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER: Elizabeth Bias

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant: Elizabeth Tripp
(Address) 1936 Brunt St

15 Filed....., 19..... [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis
(Duration) yrs. 6 mos. 1 ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 1 ds.

July 25/27 Signed G E Yates M. D.
(Attending Physician or Coroner)
(Address) 143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial July 26 27

20 UNDERTAKER: Samuel L Brumley & Bro ADDRESS 542 W Baltimore

very important. See instructions on back of certificate.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24197

90 E 24197

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1725 Lancaster St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MICHALINA GUC,

(a) RESIDENCE NO. 1725 Lancaster St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ludwig Guc,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at home, 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) German Poland,

PARENTS

10 NAME OF FATHER Francis Franskowiak,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) German Poland,

12 MAIDEN NAME OF MOTHER Bregida Nowak,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) German Poland,

14 Informant Mrs. Frances Sadowski,

(Address) 1725 Lancaster Street

15 Filed ..... 19 .....

C. HARRISON JONES, M. D.

Per ..... Registrar

JUL 25 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July - 23 - 27

17 I HEREBY CERTIFY, That I attended deceased from July - 14 - 1927, to July 22 1927,

that I last saw h.. alive on July 21 — 1927.

and that death occurred, on the date stated above, at 10-45 A. m.

The CAUSE OF DEATH* was as follows:

Senile - Cardio - Vascular Dis.

(duration) 8-10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage —

Coma — (duration) yrs. mos. 8 ds.

18 Where was disease contracted

if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy - Rosary.	July 26. 1927.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 900 S. Conn St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24198

CERTIFICATE OF DEATH.

188-083

E 24198

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Chambers

(a) RESIDENCE NO. 1110 May St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: col

5 Single, Married, Widowed, or Divorced, (write the word): W

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unk.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	about		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Jno Chambers

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Unk

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Mary C. Chambers

(Address): 333 Canon St. Charlestown

15 Filed ..... 19 ..... Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21. 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract of Skull
accidentally sustained by
auto knock

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J. Reese M. D.

July 24 . 19 (Address) 1627 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charlestown Md.

Date of Burial 7/26 1927

20 UNDERTAKER: Byron Wright

Address: Mt Olivet St.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 ✓ E 24199

E 24199

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~Johns Hopkins Hospital~~ 8-12 ✓ St. 8 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth A. Reitz

(a) RESIDENCE NO. 1213 N. Patterson Park Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2/6 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Sept 9/1917

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	9.	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Walter E. Reitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Elmyra Oswinkle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Walter E. Reitz

(Address) 1213 Patterson Park Ave

15 Filed _____, 19____ Per _____ Registrar

JUL 25 1927

C. M. ROBERTS JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

7/23/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h___ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Endocarditis-Chorea

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Calvert M. D.

(Coroner)

7/25/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial July 26 1927

20 UNDERTAKER Robt J Turner ADDRESS 944 S Broadway

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 24200 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

46. E 24200

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 Robb ST. 9-46 WARD)

2-FULL NAME Maud McLeonas

(a) RESIDENCE NO. 2023 Robb ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 45 yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Robert G. McConas

6 DATE OF BIRTH (month, day, and year): SEP 27-1854

7 AGE — Years: 72 — Months: 9 — Days: 27 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. wife

(b) General nature of industry, business, or establishment in which employed (or employer): X

(c) Name of employer: X

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant (Address): 2023 Robb St

15 Filed JUL 25 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): JUL 24 1927

17 I HEREBY CERTIFY, That I attended deceased from JUL 15 1927, 19 ... to JUL 23 1927, 19 ...

that I last saw h... alive on JUL 23, 19 ...

and that death occurred, on the date stated above, at 4:20 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
probably Chronic nephritis

(duration) X yrs. X mos 4 ds.

CONTRIBUTORY (Secondary) Carcinoma cervix uteri (duration) 7 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones M. D.

JUL 24 1927 (Address) 928 N. ... ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cemetery — DATE OF BURIAL: 7/27 1927

20 UNDERTAKER: George J. Ruth — ADDRESS: 1738 Harford ave

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24201

CERTIFICATE OF DEATH.

100-001

E 24201

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 32 Kelley ave. St. 27-54 Ward)

2-FULL NAME Florence Johnson

(a) RESIDENCE NO. 32 Kelley ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Unknown

14 Informant Pearl Johnson

(Address) 32 Kelley Ave

15 Filed _____ 19____ C. HARRISON JONES, M. D.

Registrar

7-27-1927 Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. Harrison Jones M. D.
(Coroner)

July 25, 1927 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial July 25 1927

20 UNDERTAKER Virginia A. Brooks ADDRESS 1463 N Carey

Use black ink. Fill in all blanks with full data or the word "unknown" or the abbreviation "unk." or the letters "na" (not applicable). Do not use ditto marks. Be sure to sign certificate. Physician, coroner, undertaker, informant, and registrar are each responsible for the accuracy of the items which relate to his duties. See instructions on back of certificate. Every certificate must be complete and correct. Each item is very important.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24202 161-096 ✓ E 24202

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No. 1740 Clarkson St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs Robt C Ickes

(a) RESIDENCE NO. 1740 Clarkson St. 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 22/27

7 AGE — Years | Months | Days | IF LESS than 1 day.....hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Robt C Ickes Jr

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Md

12 MAIDEN NAME OF MOTHER: Theresa Thomas

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

11 Informant: Mrs T C Ickes

(Address): 1740 Clarkson

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1927

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1927, to July 22, 1927, that I last saw h in alive on July 22, 1927, and that death occurred, on the date stated above, at 1-15 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(5 Mo. Utero Gestation)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H E L Campbell, M. D.

7-22-1927 (Address) 1644 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

JUL 26 1927 Per 1552 RH

Commissioner Health

* very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24203 ✓ 54 E 24203

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hosp. St. 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Norman

(a) RESIDENCE NO. 252 W. Hoffman St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years 40 Months Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) atlanta Ga

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Hospital records

(Address) provident Hosp.

15 Filed JUL 25 1927 C. HAMPSON JONES, M. D. Registrar

By Rcd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

7-24-27

17 I HEREBY CERTIFY, That I attended deceased from 6-21-, 1927, to 7-24, 1927,

that I last saw her alive on 7-24, 1927,

and that death occurred, on the date stated above, at 1030 P m.

The CAUSE OF DEATH* was as follows:

Pellagra

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? atlanta Ga

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Thos. Dr Saunders, M. D.

, 19 (Address) 1029 N Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn Cem	7/26 1927
20 UNDERTAKER	**ADDRESS**
Saml Easton	916 Pa Ave

very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24204 E 24204

CERTIFICATE OF DEATH.

24-201

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2624 W. Franklin St. 20-69 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Richard Gunther.

(a) RESIDENCE. No. 2624 W. Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Gunther

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: Years 55; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Nicholas Gunther.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Catherine Gunther 2627 W. Franklin St

15 Filed . 19 . Registrar

C. HAMPSON JONES, M. D.

JUL 25 1927

Per: RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1927, to July 23, 1927; that I last saw h[illegible] alive on July 22, 1927; and that death occurred, on the date stated above, at 8.40 A. m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis, Myocardial insufficiency.

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): cerebral hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm Michel M. D.

7/23/1927 (Address) 2901 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 7/26 1927

20 UNDERTAKER: Daniel Easton

ADDRESS: 916 Paca St

(See instructions on back of certificate.)

Spec.—1-12-23—M&T—500 Bks.

E 24205

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24205

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Pierce ST. 17-76 WARD)

2-FULL NAME Joseph Addie

(a) RESIDENCE NO. 712 Pierce ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie Addie

6 DATE OF BIRTH (month, day, and year): 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Public

(c) Name of employer: Abe Simmons

9 BIRTHPLACE (city or town) (State or country): Florida

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Florida

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Florida

14 Informant: Bessie Addie
(Address): 712 Pierce St

15 Filed 2-5 1927, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1927 to July 27th, 1927

that I last saw him alive on July 26th, 1927

and that death occurred, on the date stated above, at 1:10 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 2 yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary): Acute Nephritis

(duration) ..... yrs. 1 wk. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Hicks, M. D.

1927 (Address) 724 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 7/27 1927

20 UNDERTAKER: Daniel Easton

ADDRESS: 916 Pierce

Spec—12-23-21—E.B.R.S.—400 Bks.

E 24206

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24206

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1725 W. North Ave. St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Hinton

(a) Residence No. 1725 W. North Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-[illegible] Married, Widowed, or Divorced, (Write the word.)
female	white	Married

5a-If married, widowed or divorced WIFE of Erasmus O. Hinton

6-DATE OF BIRTH (month, day and year) June 29. 1852

7-AGE. 75 yrs. 0 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, Abraham Powelson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York

12-MAIDEN NAME OF MOTHER, Elizabeth Ayres

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New York

11- (Informant) Erasmus O. Hinton

(Address) 1725 W. North Ave.

15- Filed [illegible] 19 [illegible] Registrar.

[illegible] C. HARRISON JONES, M. D.

[illegible] Per [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 23. 1927

17- I HEREBY CERTIFY, That I attended deceased from May 19 1926 to July 23d 1927 that I last saw her alive on July 23d 1927 and that death occurred, on the date stated above, at 9:45 A.m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Howard C. Dilworth M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Petersburg Va.	July 26 1927
20-UNDERTAKER, Hughes & Cross Inc	ADDRESS 424 N. Broadway

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24207 ✓ 129 E 24207

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (Westport)

CITY OF BALTIMORE: (No. Annapolis Road ST., 75-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Blackinger

(a) RESIDENCE NO. Annapolis Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred LIFE yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ulrich Blackinger

6 DATE OF BIRTH (month, day, and year): 7/15/1860

7 AGE — Years: 67 Months: mo Days: 10. If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Conrad Derenzorder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Catherine Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Fred Bosnyske. (Address) Westport.

15 Filed JUL 25 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1927

17 I HEREBY CERTIFY, That I attended deceased from 1926 to July 25 1927.

that I last saw her alive on June 24, 1927

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Abscess Intestines.

Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Raymond Abrams, M. D.

July 25. 1927 (Address) Gatelund.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/CREMATION OR REMOVAL: Lawson Park Cem. DATE OF BURIAL: July 28 1927

20 UNDERTAKER: Edgar B Cook ADDRESS 1002 N Eutaw St

Spec.-7-17-26—A Co.—200 Bks.

E 24208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 24208

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1320 Mary Knoll St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hans Tyano

(a) RESIDENCE NO. 615 Fremont Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
mal	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17. 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John E. Hurst & Co.

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Evans

11 BIRTHPLACE OF FATHER (City or town) Harford Co.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Cuser

13 BIRTHPLACE OF MOTHER (City or town) Balto

(State or country) Md

14 Informant James S. Dye

(Address) 615 Fremont Ave.

15 Filed JUL 25 1927, 19 Per

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 7 1927, to July 24 1927

that I last saw h alive on July 24 1927

and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Pleuritis

+ Pneumonitis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Bronchi-Pneu.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Wm. E. Hurst, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — Date of Burial July 26 1927

20 UNDERTAKER John O. Mitchell & Sons — ADDRESS 1900 Eutaw Pl.

very important. See instructions on back of certificates.

Spec. 7-17-26 A Co. 200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24209

CERTIFICATE OF DEATH

E 24209

1-PLACE OF DEATH

REGISTERED NO. 129

City of BALTIMORE: (No. 822 S Luzerne Ave St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nepumocen Lisek

(a) RESIDENCE NO. 822 S Luzerne Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 8 1847

7 AGE: Years 80 Months 2 Days 15 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) POland

14 Informant Mrs Kecial

(Address) 822 S Luzerne Ave

15 Filed ; 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 July 23 1927

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1927, to July 23, 1927, that I last saw h[illegible] alive on July 23, 19, and that death occurred, on the date stated above, at 1[illegible] A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis unknown

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic interst nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

7/24 1927 (Signed) Frank A. Janiszewski M. D.

(Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. Date of Burial July 26 1927

20 UNDERTAKER: John M Wilber ADDRESS 1503 Bank St

25 1927 C. LAMPSON JONES, M. D.

Registrar

very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24210

CERTIFICATE OF DEATH

44 E 24210

1-PLACE OF DEATH

REGISTERED NO. .....

City of BALTIMORE: (No. 1821 Bank St St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Swierczewski

(a) RESIDENCE NO. 1821 Bank St St. ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anastasia Swierzewski

6 DATE OF BIRTH (month, day, and year) June 27 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	45		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 034

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer Store Kepper

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Poland

PARENTS

10 NAME OF FATHER Cyprazan Swierczewski

11 BIRTHPLACE OF FATHER (City or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Polito

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

14 Informant Anastasia Swierczewski
(Address) 1821 Bank St

15 Filed ....., 19.... C. HUNSON JONES, M. D. Registrar
JUL 25 1927 Per RDH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
July 24 1927

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1926, to July 24, 1927, that I last saw him alive on July 24, 1927, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

..... (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 11 26

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John J. Kruger, M. D.

, 19 (Address) 1621 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Stanislaus Cem	July 27 19 27

20 UNDERTAKER ..... ADDRESS

John R. Weber 1803 Bank St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24211

CERTIFICATE OF DEATH.

E 24211

181-E 24211

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1211 Mosher St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel A. Dorsey

(a) RESIDENCE NO. 1211 Mosher St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

male colored married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. S. A. Dorsey

6 DATE OF BIRTH (month, day, and year) March 24, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Davis Chemical Co.

9 BIRTHPLACE (city or town)

(State or country) St Mary Co Md.

PARENTS

10 NAME OF FATHER Joshua Dorsey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Jane Hicks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Samuel Dorsey

(Address) 1211 Mosher St

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Substitution of metric acid fumes.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Headley M. D.

(Coroner)

19 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery Date of Burial July 26 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 1303 Presstman St.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24212

CERTIFICATE OF DEATH.

E 24212

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 642 Haw St. 22-30 Ward)

2-FULL NAME Genevia Wise

(a) RESIDENCE NO. 642 Haw St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Willie Wise

6 DATE OF BIRTH (month, day, and year): 1895

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
32	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Geo Rawlings

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Maggie Wallace

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Maggie Fowler

(Address) 642 Haw St

15 Filed_____, 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Carcinoma Pelvis Dis.

(duration) Yrs. ____ mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

July 23/27 Signed: G C Hades, M. D. (Coroner)

(Address) 1438 Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leland Creek Church Calvert Co

Date of Burial: 7/26 27

20 UNDERTAKER: Daniel Foster

ADDRESS: 916 Pa Ave

very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24213

E 24213

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 831 Ealverton Road ST. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Meyers

(a) RESIDENCE. No. 831 Ealverton Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Milton M. Meyers

6 DATE OF BIRTH (month, day, and year) June 20. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Riggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Amanda Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Milton M Meyers

(Address) 831 Ealverton Road

15 Filed JUL 26 1927 19 HAMILTON JONES, M. D. Registrar

By ARK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21st, 1927, to July 25th, 1927,

that I last saw her alive on July 25th, 1927,

and that death occurred, on the date stated above, at 1.00 a. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) D. Edgar Tilp, M. D.

7/25 1927 (Address) 2919 Ellamont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	July 27 1927
20 UNDERTAKER	ADDRESS
J. F. Cook	502 E Madison

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24214

E 24214

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hosp. St. 16-22 Ward)

2-FULL NAME Mary M. Block

(a) RESIDENCE NO. 1934 Riggs Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew J. Block

6 DATE OF BIRTH (month, day, and year): Nov 26 1853

7 AGE — Years: 74 Months: 7 Days: 28 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: George Gustine

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Irish

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Andrew J. Block

(Address): 1934 Riggs Ave

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennigan M. D.

(Coroner)

19 27 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Date of Burial 7/27 1927

20 UNDERTAKER: J. Wm. Cook ADDRESS 501 E. Madison

JUL 26 1927 Pm

C. HAMILTON JONES, M. D.

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

148

E 24215

CERTIFICATE OF DEATH

E 24215

REGISTERED NO.

1-PLACE OF DEATH Colonial Hospital

City of BALTIMORE: (No. Lanvale & Mount St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ella Beyer

(a) RESIDENCE NO. 1918 Walbrook Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Mrs. Edward Beyer.

6 DATE OF BIRTH (month, day, and year): Sept 13th 1897

7 AGE — Years: 29 Months: 10 Days: 7 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Samuel C. Brayden

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Dirtion

13 BIRTHPLACE OF MOTHER (city or town): Baltimore Co.

(State or country)

14 Informant: Mrs. Edward Beyer

(Address): 1918 Walbrook Ave

15 Filed ....., 19 .....

Registrar

RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: July 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23rd, 1927, to July 24th, 1927, that I last saw her alive on July 24th, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis of Pregnancy (Nephritic Toxemia of Pregnancy) with Uremic Coma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pregnancy

(duration) yrs. 7 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Test of Urine

(Signed) Julius Bialostosky, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: July 28 1927

20 UNDERTAKER: Wm Cook — ADDRESS 502 E Wash St

Hth

Property claimed. Exact statement of property is not required, but it may be of very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24216 E 24216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 266

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts. 19-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Marshall.

(a) RESIDENCE NO. Tylerton Md. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos 20 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Wh.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hatsen Marshall

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: about 33 yrs — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Tylerton, Md

PARENTS

10 NAME OF FATHER: Wm. G. Hoffmore

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Maggie Bozedon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Tylerton Md

14 Informant: Vaughn Smith

(Address): Tylerton Md

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/10/ 1927

17

I HEREBY CERTIFY, That I attended deceased from 5/20/27. 19 . to 6/10/27. 19 .

that I last saw h[illegible] alive on 6/10/27. 19

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goiter,

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Dilitation of heart.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-9-27

Was there an autopsy? No

What test confirmed diagnosis? Hyperplasia of Thyroid

(Signed) William Walker, M. D.

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tylerton, Md — DATE OF BURIAL: Jan, 12 1927

20 UNDERTAKER: John A. Bradshaw — ADDRESS: Crisfield

D.C. 1427 — HARRISON JONES, M. D.

ZR.

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24217

CERTIFICATE OF DEATH.

74201

E 24217

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 2202 Linden Ave. St., 1359 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Rosenthal

(a) RESIDENCE NO. 2202 Linden Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Rosenthal

6 DATE OF BIRTH (month, day, and year) April 17, 1850

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Furniture

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.

(State or country) Md.

PARENTS

10 NAME OF FATHER Marcus Rosenthal

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Fannie ———

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mr. Mendes Hecht (Son-in-law)

(Address) 2202 Linden Ave.

15 Filed....., 19.... Per_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24/ 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h____ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] (Coroner) M. D.

7/25. 1927 (Address) 1632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Baltimore Hebrew Cem. — Date of Burial 7/26/ 1927

20 UNDERTAKER David Sondheim — ADDRESS 118-20 W. Mt. Royal Ave.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24218

CERTIFICATE OF DEATH.

90 E 24218

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) W. Balto Gen Hospital (WARD) 5661

2-FULL NAME Henry M. Warner

(a) RESIDENCE NO. 2542 Clifton Ave ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If ~~married~~, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Sadie R Warner

6 DATE OF BIRTH (month, day, and year) April 22, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	71	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Express business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Baltimore Md.~~ Hagerstown Md.

PARENTS

10 NAME OF FATHER ? Sheppard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Robert Warner
(Address) 2542 Clifton Ave

15 Filed ..... 19 .....
C. HARRISON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1927, to July 25, 1927
that I last saw ~~him~~ alive on July 25, 1927
and that death occurred, on the date stated above, at 11.20 A. m

The CAUSE OF DEATH* was as follows:

Acute Dilatation Cardio - Vascular Disease
General Anasarca

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Louis T. Lavy, M. D.
7/25, 1927 (Address) W. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL JUL 27 1927 19

20 UNDERTAKER Geo W Little ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24219

CERTIFICATE OF DEATH.

90 E 24219

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1114 N. Fulton Ave Ward 16-22)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Williams

(a) RESIDENCE NO. 1114 N. Fulton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

6a If married, widowed, or divorced (or) WIFE of: Charles H Williams

6 DATE OF BIRTH (month, day, and year): March 25 1858

7 AGE: Years 69 Months 3 Days 29 IF LESS than 1 day.....hrs. or.....min. 30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Newport News Va

PARENTS

10 NAME OF FATHER: Sheppard

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Virginia

14 Informant: Charles H Williams

(Address): 1114 N Fulton Ave

Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) D. J. Young M. D.
(Coroner)

19 2 (Address) 2 S Edmondson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newport News Va — Date of Burial 19

20 UNDERTAKER: Geo M Little — ADDRESS

very important. See instructions on back of certificate.

Spec—12-23-'21—E.P.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

24220

CERTIFICATE OF DEATH.

E 24220

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 519 S. Bentalou St. 20-K Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Brownes

(a) Residence No. 519 S. Bentalou St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Brownes

6-DATE OF BIRTH (month, day and year) Apr. 17-1857

7-AGE. 70 yrs. 3 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14-Informant Frederick Brownes

(Address) 519 S. Bentalou St

Filed JUL 26 1927 HAMPSON JONES, M.D. Registrar.

Per J.H.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 23/27.

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to July 23 1927.

that I last saw h.. alive on July 22 1927

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) yrs. mos. ds. In Hosp.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

7/25. 1927 (Address) 54 S Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cemetery DATE OF BURIAL. July 26 1927

20-UNDERTAKER George E. Johnson ADDRESS 216 Frederick Ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24221
1-PLACE OF DEATH

170 ✓

REGISTERED NO. E 24221

City of BALTIMORE: (No. 3621 Forrest Park Ave. St. 15-61 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Edison Miller

(a) RESIDENCE NO. 3621 Forrest Park Ave. St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 10 mos. 19 How long in U. S., if of foreign birth? 49 yrs. 10 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Stubbs Miller

6 DATE OF BIRTH (month, day, and year) Sept-5-1877

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	49	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President of

(b) General nature of industry, business, or establishment in which employed (or employer) The International

(c) Name of employer Syndicate Baltimore

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER William R. Miller

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Cassard

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Robert M. Miller (brother)
(Address) 3510 Powhatan Ave. City.

15 Filed ....., 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) [illegible] 192[illegible]

17 I HEREBY CERTIFY, That I (or) had charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

[illegible]

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible], M. D.
(Coroner)

, 19[illegible] (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death / yrs., — mos., — ds. In the state — yrs. — mos., — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — Date of Burial July-26-2[illegible]

20 UNDERTAKER STEVENS & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 103 W. NORTH AVE.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 24222

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 24222

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt. Hope Retreat ST., (or WARD) 28-63

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas F. Hogan

(a) RESIDENCE No. 711 Hope ST., 28 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 61 yrs. 5 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb-23-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer) Plastering

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) unknown New Jersey

PARENTS

10 NAME OF FATHER William Hogan

11 BIRTHPLACE OF FATHER (city or town) ? ? (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Corcoran

13 BIRTHPLACE OF MOTHER (city or town) ? ? ? (State or country) Ireland

14 Informant Friends 711 Hope

(Address) 711 Hope St. Balto. Md.

15 Filed ..... 19 ..... Registrar

JUL 26 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-25-1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926, to July 25, 1927.

that I last saw him alive on July 25, 1927,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Clinical Exam

(Signed) C. B. Emson, M. D.

7-25, 1927 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Brunswick N.J.	July 26 1927
20 UNDERTAKER	ADDRESS
Stewart & Mondel	Balto.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24223

CERTIFICATE OF DEATH

4th E 24223

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospitals 15-21 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Aaronson

(a) RESIDENCE NO. 1711 N Appleton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Rebecca Aaronson
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
54				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Peddler.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Solomon Aaronson
11 BIRTHPLACE OF FATHER (City or town) Russia
(State or country)
12 MAIDEN NAME OF MOTHER Evelyn
13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Rebecca Aaronson
(Address) 1711 N Appleton

15 Filed JUL 26 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1927, to July 25, 1927,
that I last saw him alive on July 25, 1927
and that death occurred, on the date stated above, at 5:15 a m.
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. Blumer, M. D.
, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Hebrew Rawdale	July 26 1927
20 UNDERTAKER	**ADDRESS**
Jacob Levin	1439 Lorman St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24224

CERTIFICATE OF DEATH.

129 v **E 24224**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 516 Orchard St. 17-24 Ward)

2-FULL NAME John H Luckett

(a) RESIDENCE NO. 516 Orchard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Lucky

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Lewis Lucky

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Frederick, Md

12 MAIDEN NAME OF MOTHER Jane Owens

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Frederick, Md

14 Informant Gertrude Lucky

(Address) 516 Orchard St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 19, 19 27, to July 24, 19 27

that I last saw h.. alive on July 25, 19 27

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic parenchymatous nephritis

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? by recall

(Signed) H N Tompkins, M. D.

7/28 1927 (Address) 1014 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial 7-27 1927

20 UNDERTAKER George T. A. Gibson ADDRESS 1735 Druid Hill Ave

very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 E 24225

E 24225

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospitals Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. H. Butler

(a) RESIDENCE NO. 1219 W. James St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced. (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Rachel Butler

6 DATE OF BIRTH (month, day, and year): 1873 Dec 25

7 AGE: Years 53 Months 6 Days 26

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Louisiana

(State or country)

PARENTS

10 NAME OF FATHER: Isaac Butler

11 BIRTHPLACE OF FATHER (City or town): Indiana

(State or country)

12 MAIDEN NAME OF MOTHER: Annie

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Indiana

14 Informant: Mrs Rachel Butler

(Address) 1235 Ashland Ave

15 Filed ..... 19 ..... C. HAMILTON JOHNSON Registrar

JUL 26 1927 per RJC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 7-21-27

17 I HEREBY CERTIFY, That I attended deceased from 6-11-27 19 ..... to 7-21- 19 27

that I last saw him alive on 7-21- 19 27

and that death occurred, on the date stated above, at 10:20 a. m.

The CAUSE OF DEATH* was as follows: Cancerous Lawe & Jaw.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. Heycock M. D.

19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: July 27 1927

20 UNDERTAKER: Robert F. Williams — ADDRESS: 1515 Mt Ave

very important. See instructions on back of certificates.

Spec.-7-15-26-A Co.-1200 Bks.

E 24226

20507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x84 E 24226

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Thomas

(a) RESIDENCE NO. Cumberland-Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Mar-

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Lillie Thomas

6 DATE OF BIRTH (month, day, and year): ~~December~~.

7 AGE: Years 36 Months Days IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Car man - B+O.R.R

(b) General nature of industry, business, or establishment in which employed (or employer): 073

(c) Name of employer

9 BIRTHPLACE (city or town): Cumberland

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Uriah Thomas

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Pa-

12 MAIDEN NAME OF MOTHER: Amanda Keyser

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Pa

14 Informant: Records

(Address): ~~JOHNS HOPKINS HOSPITAL~~

15 Filed ..... 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 19 27.

17 I HEREBY CERTIFY, That I attended deceased from July 24th, 19 27, to July 26, 19 27,

that I last saw h~~e~~r alive on July 26, 19 27,

and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (Cer

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/20/27

Was there an autopsy? yes

What test confirmed diagnosis? Operation + autopsy

(Signed) George G Finney, M. D.

7/26/27 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md — Date of Burial 7/28/27

20 UNDERTAKER: Joseph Airey — ADDRESS 221 Bway

very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

24227

CERTIFICATE OF DEATH.

E 24227

167-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 S. Pat Pk ave. ST., 1-3 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Buck

(a) RESIDENCE No. 420 S. Pat Pk ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Hattie Buck~~

6 DATE OF BIRTH (month, day, and year) July 25, 1927.

7 AGE Years ..... Months ..... Days ..... If LESS than 1 day, hrs. ..... or 3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER William H. Buck

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Groghi

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

14 Informant William H. Buck.
(Address) 420 S. Pat Pk ave.

15 Filed JUL 26 1927, 19 ..... Per ..... Registrar

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to July 25, 1927, that I last saw h[illegible] alive on July 25, 1927, and that death occurred, on the date stated above, at 2 03 8. m.

The CAUSE OF DEATH* was as follows:

Premature Baby - 5 mos.
Prostration

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ?
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. W. Kenney, M. D.

, 19 (Address) 1514 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St. Stanislaus Cem. July 26 1927

20 UNDERTAKER — ADDRESS

George A. Weber 2205 Bank st

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24228

31 E 24228

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Beverly

(a) RESIDENCE NO. 1116 McCulloh st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dishwasher

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Carrie Parker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 19 C. Hawkins M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 11, 19 27 to July 24, 19 27,

that I last saw him alive on July 24, 19 27,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis, Pleurisy with effusion.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) L. E. Medlin, M. D.

7-24-, 19 27 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn	JUL 26 1927 19
20 UNDERTAKER Dane Easton	ADDRESS 916 Penna Ave

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24229

CERTIFICATE OF DEATH

117 E 24229

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No. St. 17-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ERTIMUS POWELL

(a) RESIDENCE NO. 714 Little Gaye St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 16- 77

7 AGE: Years 50 Months Days 7 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer): Holton Furniture

(c) Name of employer Chas. Westey Inc 070

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Marie Murray

(Address) 1235 Orleans

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1927, to July 24, 1927, that I last saw him alive on July 24, 1927, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Suppurative peritonitis (general) subsequent to ruptured and infected appendix

(duration) yrs. mos. 2 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of 7/24/27

Was there an autopsy? yes

What test confirmed diagnosis? Operation - autopsy

(Signed) L. C. Lumpkin, M. D.

7/24 1927 (Address) Un. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL) W. [illegible] Cem Date of Burial July 25 1927

20 UNDERTAKER [illegible] ADDRESS [illegible]

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24230

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002 E 24230

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2443 Llewellyn Ave 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Young

(a) RESIDENCE NO. 2043 Llewellyn Ave Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (C) yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 25 1927

7 AGE	Years	Months	Days	IF LESS than 1 day..... hrs. or 2 min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER James Young

11 BIRTHPLACE OF FATHER (City or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Chuk

13 BIRTHPLACE OF MOTHER (city or town) NC
(State or country)

14 Informant James Young
(Address) 2043 Llewellyn Ave

15 Filed ..... 19 ..... Registrar

C. HARRISON JONES, M. D.

JUL 26 1927 Per 1568 RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25 1927 to July 25 1927, that I last saw h.. alive on July 25 1927, and that death occurred, on the date stated above, at 1.52 p. m.

The CAUSE OF DEATH* was as follows:

Fetal Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted No

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

July 25 1927 (Address) 608 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial JUL 26 1927

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Commissioner of Health,

Per Wm. F. WOODALL

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24231

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24231

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Central Ave. ST. WARD) REGISTERED NO. 161-902

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Loffler

(a) RESIDENCE NO. 917 N. Central Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23, 1927

7 AGE Years Months Days If LESS than 1 day, 8 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

PARENTS

10 NAME OF FATHER John J. Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Pauline Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed ..., 19 1569 RPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-23, 1927, to 6-23, 1927, that I last saw her alive on 6-23, 1927, and that death occurred, on the date stated above, at 10 00 A. m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) C H Peckham, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL, 19

20 UNDERTAKER — ADDRESS

FOR IS very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24232

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 24232

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Waters

(a) RESIDENCE NO. 1320 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race Female White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 65 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) do

12 MAIDEN NAME OF MOTHER do

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) do

14 Informant

(Address)

15 Filed , 19 Registrar

1574

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1927 to July 20 1927, that I last saw her alive on July 20, 1927, and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Hospital Diagnosis

(Signed) [illegible], M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interred and buried in Sacred Heart Cem

Date of Burial Aug 19 1927

20 UNDERTAKER John J Fahey & Son

ADDRESS 1318 Eight St.

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24233

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24233

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1407 S. Charles St. 23-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie F. O'Connor

(a) RESIDENCE NO. 1407 S. Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 186[illegible]

7 AGE: Years 63 Months – Days – IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Laurence O'Connor

11 BIRTHPLACE OF FATHER (City or town) Bal[illegible] Md

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Murray

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Ireland

14 Informant Mrs Edw. Griffith

(Address) 1407 S. Charles St.

15 Filed ..... 19 .....

Per .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 19 27

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 27 to July 24 19 27

that I last saw h[illegible] alive on July 23 19 27

and that death occurred, on the date stated above, at 7:20 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cancer of stomach

..... (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? –

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hawkins M. D.

7:20 1927 (Address) 1 E. Randall Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

Date of Burial July 27 1927

20 UNDERTAKER Margaret S. Flynn

ADDRESS 114 N. Eighth St.

very important. See instructions on back of certificates.

JUL 28 1927 C. HAMILTON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24234 E 24234

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 1834 Light St. 23-32 Ward)

REGISTERED NO. 74001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M. Ulz

(a) RESIDENCE NO. 1834 Light St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Casper Ulz

6 DATE OF BIRTH (month, day, and year): Dec. 12 1856

7 AGE: Years 70 Months 7 Days 13 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Becker

11 BIRTHPLACE OF FATHER (City or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs Mary Ulz (Address) 1834 Light St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 27

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1927, to July 25, 1927

that I last saw h[illegible] alive on July 23, 1927

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows: Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

7-26, 1927 (Address) 20 Hendrix

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: July 29 1927

20 UNDERTAKER: Margaret J. Flynn — ADDRESS: 14 Wright St

C. HAMILTON JONES, M. D.

1521

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24235

CERTIFICATE OF DEATH

129

E 24235

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1210 Hanover St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Coleman

(a) RESIDENCE NO. 1210 Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James P. Coleman

6 DATE OF BIRTH (month, day, and year): Dec 5, 1843

7 AGE: Years 81 Months 7 Days 19

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Samuel Johnson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Penn.

12 MAIDEN NAME OF MOTHER: Josephine Gonzales

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Spain

14 Informant: Howard Coleman

(Address): 1210 Hanover St

15 Filed ..... 19..... Registrar

JUL 26 1927 C. HAMPSON JONES, M. D.

Per R.R.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1927

17 I HEREBY CERTIFY, That I attended deceased from July 13th, 1926, to July 24th, 1927.

That I last saw her alive on July 23rd, 1927

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis and chronic interstitial nephritis

(duration) 1 yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) — yrs. — mos. 11 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Geo. F. Weibel, M. D.

19 27 (Address) 1104-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: July 27 1927

20 UNDERTAKER: Margaret J. Flynn — ADDRESS: 1211 Light St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24236

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24236

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 W. Fayette ST. 19-27 WARD)

2-FULL NAME Nunzio Maranto

(a) RESIDENCE No. 1703 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Maranto

6 DATE OF BIRTH (month, day, and year) Aug 4 - 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	45	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurateur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Nunzio Maranto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosaria DiFrancisco

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Italy

14 Informant Victoria Maranto
(Address) 1703 W. Fayette st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-23, 1927, to 7-26, 1927, that I last saw him alive on 7-26, 1927, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with Metastasis in liver.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Gastro intestinal hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) S. Dragaro, M. D.

7-26, 1927 (Address) 1604 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	July 28 27

20 UNDERTAKER T. A. Schwaeter ADDRESS 703 Hanover

JUL 1927 HAMILTON JONES, M.D.

Spec.—12-9-25—A Co.—200 Bks.

E 24237.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24237.

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 Northern Parkway St., ward) or

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Murray Lower

(a) RESIDENCE NO. 6 Northern Parkway St. ward or maple ave

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

3a If married, widowed, or divorced HUSBAND (or) WIFE of: William H Lower

6 DATE OF BIRTH (month, day, and year): June 15 1858

7 AGE: Years 69 | Months 1 | Days 10 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore City

(State or country):

PARENTS

10 NAME OF FATHER: George L Kess

11 BIRTHPLACE OF FATHER (city or town): Balto County

(State or country):

12 MAIDEN NAME OF MOTHER: Hester Constene Jones

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country):

14 Interment (Address): Mrs George W Yeunce 6 Northern Parkway.

15 Filed ..... A. D. 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1927

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to July 25, 1927, that I last saw h.. alive on July 25, 1927, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clarence Jones M. D.

July 28 1927 (Address) 4708 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: July 28 1927

20 UNDERTAKER: W E Esson — ADDRESS: 8 H W 37th

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24238

CERTIFICATE OF DEATH.

74-001

E 24238

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE (No.) 432 N. Grant St. 5-8 (Ward)

2-FULL NAME Jno. Healey

(a) RESIDENCE NO. 432 N. Grant St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 9th 1867

7 AGE: Years 60 Months 7 Days 15 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): Loyola High School

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Michael Healy

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Salmon

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Mrs. Elfa Worthington

(Address) 19 N. Saratoga St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

18 CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

July 26 (Coroner)

19 27 (Address) 1637 Penna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 2 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — Date of Burial: 7/27/1927

20 UNDERTAKER: C. J. Fanning & Son — ADDRESS: 1938 E. Lafayette Ave

very important. See instructions on back of certificate.

C. HERBERT JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24239

CERTIFICATE OF DEATH.

31 E 24239

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2035 McCulloh St. (WARD) 14-20

2-FULL NAME Jas. P. Blackwell

(a) RESIDENCE NO. 2036 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Carrie Blackwell

6 DATE OF BIRTH (month, day, and year): July 29-1902

7 AGE: Years 24 — Months 11 — Days 26 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Jas Blackwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Hammond Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Carrie Blackwell 2036 McCulloh

15 Filed: C. HAMPSON JONES, M. D. Registrar

Per

G 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July June 25 1927

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1927, to July 26 1927, that I last saw h[illegible] alive on July 25, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —no

Was there an autopsy?

What test confirmed diagnosis? Clin. Exam

(Signed) Ramsay D. Wagner M. D.

(Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lobleburg Va.

DATE OF BURIAL: 7/27/1927

20 UNDERTAKER: Mrs. Geo. E. Holland

ADDRESS: 163 Druid Hill ave

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

24240

CERTIFICATE OF DEATH.

162 E 24240

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 Landau Ave St., 20-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Carroll

(a) RESIDENCE NO. 114 Landau Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 mos. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26-27

7 AGE: Years | Months | Days | IF LESS than 1 day.....hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Benard Carroll

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md

12 MAIDEN NAME OF MOTHER Celia Neville

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Mrs C. Carroll

(Address) 420 Forest Ave

15 Filed ..... 19 ..... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26-27 19

17 I HEREBY CERTIFY, That I attended deceased from July 26 19 27, to July 26, 1927, that I last saw h— alive on July 26, 19 27, and that death occurred, on the date stated above, at 12-10 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood smear

(Signed) W. C. Knauff, M. D.

7/26, 1927 (Address) 420 Forest Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial July 27 1927

New Cathedral Cemetery

20 UNDERTAKER: H B Wagaman ADDRESS 1850 N Bway

very important. See instructions on back of certificates.

JUL 28 1927 HARRISON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24241 X 118-82 24241

CERTIFICATE OF DEATH

E 24241

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No. 4-30 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rodney Burdette

(a) RESIDENCE NO Elkridge Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widower.

6 DATE OF BIRTH (month, day, and year) Dec. 8, 1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
39		7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman

(b) General nature of industry, business, or establishment In which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick County

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Burdette

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Montgomery Co. Md

12 MAIDEN NAME OF MOTHER Christina Coons

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country) Maryland

14 Informant William R. Harris

(Address) Washington Natl Cath.

15 Filed 1927 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1927

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1927, to July 26, 1927, that I last saw h[illegible] alive on July 26, 1927, and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis following intestinal obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (Bowles & gland)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of July 24 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) J. A. Trumpkin, M. D.

7/26 1927 (Address) Un. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet, Frederick Md. Date of Burial July 29 1927

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24242

E 24242

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 30 S Abermarle St. 3-5 Ward)

2-FULL NAME Carrie Mostaw

(a) RESIDENCE NO. 30 S. Abermarle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Harry Mostaw

6 DATE OF BIRTH (month, day, and year) 3/12/1898

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	29	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Pawlowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Harry Mostaw

(Address) 30 S. Abermarle St

15 Filed JUL 27 1927 19 ___ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) ___ yrs. ___ mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ___ yrs. ___ mos. 1 ds.

July 26/27 (Signed) G C Yates M. D.

(Coroner)

(Address) 143 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baetz Cem Date of Burial 7/27 1927

20 UNDERTAKER Wm Fiedlowski ADDRESS 1618 Eastern Ave

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24243

CERTIFICATE OF DEATH.

REGISTERED NO. E 24243

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] St., [illegible] Ward)

2-FULL NAME Louis Barnes

(a) RESIDENCE NO. 3rd. ave & 7th St. Fairfield Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 20-27

7 AGE — Years: — Months: — Days: 5 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Fairfield

(State or country) Md.

PARENTS

10 NAME OF FATHER: Leon Fitaker

11 BIRTHPLACE OF FATHER (city or town):

(State or country) N. C.

12 MAIDEN NAME OF MOTHER: Nannie Banks

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant: Lena Bailey

(Address)

15 Filed....., 19..... Registrar

Per

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 27

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1927, to July 26, 1927, that I last saw h. alive on July 25, 1927, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Pictures

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. J. Coleman, M. D.

July 29, 1927 (Address) 2039 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn City Date of Burial 7 28 1927

20 UNDERTAKER: Stevenson Hall ADDRESS 753 Dolphin

JUL 27 1927 Per R.P.K.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 24244

E 24244

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1503 Johns St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Carey

(a) RESIDENCE NO. 1503 Johns St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannie M. Carey

6 DATE OF BIRTH (month, day, and year): June 25–1870

7 AGE — Years: 57 Months: 1 Days: 1 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Detective Lieut.

(b) General nature of industry, business, or establishment in which employed (or employer): 861

(c) Name of employer: Balto. Police Dept.

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Thomas Carey

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Melville

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Hannie M. Carey 1503 Johns St.

15 Filed JUL 27 1927, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1927, to July 26, 1927, that I last saw h[illegible] alive on July 26, 1927, and that death occurred, on the date stated above at 4 a. m.

The CAUSE OF DEATH* was as follows:

Ichronic Endocarditis (Chron)

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilitation

(duration) yrs. 36hrs mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirm diagnosis? none

(Signed) Edwin K. Ballard, M. D.

19 (Address) 1622 Mt Royal Ave July 26/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: July 29 1927

20 UNDERTAKER: Chas F. Evans & Son — ADDRESS: 1818 Mt Royal Ave

very important. See instructions on back of certificates.

JUL 27 1927 C. KRAMER JONES, M. D.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

X74-001

E 24245

CERTIFICATE OF DEATH

E 24245

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. ____ St. 4-30 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Ecker

(a) RESIDENCE NO. Mt. Airy, Md. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 4 ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4, 1869

7 AGE: Years 58 Months ____ Days 22 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer Self

9 BIRTHPLACE (city or town) ____ (State or country) Frederick County, Md.

PARENTS

10 NAME OF FATHER Samuel Ecker

11 BIRTHPLACE OF FATHER (City or town) ____ (State or country) Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Martha Leakins

13 BIRTHPLACE OF MOTHER (city or town) ____ (State or country) Frederick Co. Md.

14 Informant (Address) Harry Bloom Buttersville, Md.

15 Filed ____ 19 ____ Registrar

JUL 27 1927 C. HAWOOD JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1927, to July 26, 1927, that I last saw him alive on July 26, 1927, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Haemorrhage into left ventricle of brain

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? Yes

What test confirmed diagnosis? ____

(Signed) Geo. T. Hobbs, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial July 27 1927

20 UNDERTAKER C. M. Graetz & Sons — ADDRESS Baltimore, Md.

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24246

CERTIFICATE OF DEATH.

90 ✓

REGISTERED NO. E 24246

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2746 Alameda ave St.. 9-46 Ward)

2-FULL NAME Mrs Katherine M. Fowler

(a) RESIDENCE NO. 2746 Alameda ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. 19 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Newton L Fowler

6 DATE OF BIRTH (month, day, and year) July 7th 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John J Norman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma V McWilliams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Newton L Fowler

(Address) 2746 Alameda ave

15 Filed July 27 1927 H. M. JONES, M. D. Registrar

Per R A L

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1927, to July 26, 1927, that I last saw her alive on July 26, 1927, and that death occurred, on the date stated above, at 2,30 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. F. Zimmerman M. D.

July 26 1927 (Address) 2858 Harford Rd

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery Date of Burial July 29 1927

20 UNDERTAKER George S Schilling & Sons ADDRESS 1126 E. Fayette

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24247

CERTIFICATE OF DEATH.

76 E 24247

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1638 N. Carolina St. ST., 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James M. Nolan

(a) RESIDENCE NO. 1638 N. Caroline St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna A. Carter

6 DATE OF BIRTH (month, day, and year) 9/12/1865

7 AGE	Years	Months	Days	If LESS than 1 day hrs or min.
	61	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Tax Dept, Balto Md.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Nolan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Geo. John Hemstadt

(Address) 1638 N. Caroline St

15 Filed 2 7 1927. 19 Per C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1927

17

I HEREBY CERTIFY, That I attended deceased from May, 1927, to July 26, 1927,

that I last saw h[illegible] alive on July 25, 1927

and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis & Pneumonia, Hypostatic Congestion

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis & Hypertrophy of Heart

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. H. Carman, M. D.

7 27, 19 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 7/28/27

20 UNDERTAKER Geo J Reilly & Son

ADDRESS 1735 Harford

Spec.—1-12-23—M&T—500 Bks.

E 24248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24248

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-13 WARD)

2-FULL NAME Mary Malone

(a) RESIDENCE NO. Mt Hope Retreat ST., ... WARD Resident

(Usual place of abode) unknown

Length of residence in city or town where death occurred 84 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	84	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mt Hope Records Mt Hope Retreat

15 Filed ....., 19 ..... Per R.P.L Registrar

C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1923, to July 26, 1927, that I last saw h[illegible] alive on July 26, 1927, and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,
(Hemiplegia)
(Congestion of Lungs)

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Senile deterioration.

unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Milton P. Hall, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL July 27 1927

20 UNDERTAKER Stewart & Mondale ADDRESS Balto.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24249 E 24249

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1434 E Madison St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Saxton

(a) RESIDENCE NO. 1434 E Madison ST. ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years: about 58; Months; Days; If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oilcloth 023

(b) General nature of industry, business, or establishment in which employed (or employer): Horse drawn wagon

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Marys Co. Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Mattie Spoddy (daughter) 1434 E Madison st

15 Filed JUL 27 1927 19 ... Registrar C. HAMPTON JONES, M. D. CAK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1927

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1927, to July 24, 1927,

that I last saw h alive on July 24, 1927,

and that death occurred, on the date stated above, at 9 35 P. m.

The CAUSE OF DEATH* was as follows:

Tumor mass in Pylorus and ? Stomach probably Cancer

(duration) ... yrs. ... 1 mos ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis and Myocarditis (duration) 1 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Gourley, M. D.

7/26 1927 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: July 27 1927

20 UNDERTAKER: Wm F. J. Locks

ADDRESS: 1302 Lafayette

Spec.—7-17-26—A Co.—200 Bks.

E 24250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 24250

1-PLACE OF DEATH St Joseph's Hospital

City of BALTIMORE: (No. Caroline & Oliver St. 27-25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Leary.

(a) RESIDENCE NO. 118 E. Rogers Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 26, 1927

7 AGE Years Months Days IF LESS than 1 day 1 hrs. or 2 min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Daniel J. Leary

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Gengiena Sheehan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Daniel J. Leary

(Address) 118 E. Rogers Ave.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26. 27 19

17 I HEREBY CERTIFY, That I attended deceased from June 26. 19 27 to July 26 19 27

that I last saw him alive on July 26. 19 27

and that death occurred, on the date stated above, at 5'00 p. m.

The CAUSE OF DEATH* was as follows:

Premature. 6½ mo.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? et

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical —

(Signed) A Lawrence Fahney M. D.

19 (Address) 97 St. Josephs Hospital

*State the Disease Causing Death; or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: 7/27, 1927

20 UNDERTAKER: Henry W. Myers & Son — ADDRESS: 1025 N. Calvert

very important. See instructions on back of certificates.

C. Harrison Jones, M. D.

JUL 27 1927

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24251

CERTIFICATE OF DEATH.

REGISTERED NO. E 24851

1-PLACE OF DEATH Hebrew Home for Aged (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2100 E. Baltimore St. 13 (Ward) 9

2-FULL NAME Etta Levin

(a) RESIDENCE No. 2302 Callow Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Levin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Blumberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Levinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rachel Freeman (Address) 2302 Callow Ave

15 Filed July 28, 1927 (or) [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1927

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1927, to July 26, 1927, that I last saw h[illegible] alive on July 26, 1927, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Gangrene

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	July 28 1927
20 UNDERTAKER Jack Levin	ADDRESS 1439 Bank

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

2047 94E 24252 | 55E 24252

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 1568 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Selma Eisenberg

(a) RESIDENCE NO. 2117 Presbury St. Ward 11

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 3-22-26

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 1 Months 4 Days 5 IF LESS than 1 day ....hrs. or ....min.. 16 Mos.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Maurice Eisenberg

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Rel

12 MAIDEN NAME OF MOTHER Lena Cooper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Rel

14 Informant Records

(Address) Johns Hopkins Hospital

15 Filed ....19.... Registrar

JUL 27 1927 Per RMK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1927

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1927, to July 27, 1927, that I last saw h.e alive on July 27, 1927, and that death occurred, on the date stated above, at 9:00 A.m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) ....yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Epistaxis Septicaemia

(duration) ....yrs. mos. 20 ds.

18 Where was disease contracted

If not at place of death? 2117 Presbury St

Did an operation precede death? Yes Date of July 13 1927

Was there an autopsy? No

What test confirmed diagnosis? Lumbar Puncture

(Signed) J. J. Beroglity, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Blvd | Date of Burial July 29 19[illegible]

20 UNDERTAKER A. Krauss Inc. | ADDRESS 1127 Baltimore

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001 E 24253

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3300 Auchentoroly Terrace Ward) 13-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Riggans

(a) RESIDENCE NO. 3300 Auchentoroly Terrace Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Riggans

6 DATE OF BIRTH (month, day, and year) April 6, 1851

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	76	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia,

(State or country) Pa.

PARENTS

10 NAME OF FATHER John Rainier

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Barnegat, N. J.

12 MAIDEN NAME OF MOTHER Elizabeth Fell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. J.

14 Informant Miss Grace A. Riggans

(Address) 3300 Auchentoroly Terrace

15 Filed ..... 19 .....

Per .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to July 25, 1927, that I last saw h... alive on July 25, 1927, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampson Jones M. D.

19 (Address) 3300 Auchentoroly Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Greenmount	July 28 1927
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24254 — CERTIFICATE OF DEATH. — E 24254

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 17 Edgewood Ave ST. (WARD) 27-44

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Emma Harris

(a) RESIDENCE No. 17 Edgewood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Hugh Harris

6 DATE OF BIRTH (month, day, and year): April 10 1861

7 AGE — Years: 66 — Months: 3 — Days: 15 — If LESS than 1 day, hrs or min. 6

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Joseph Harris
(Address): 17 Edgewood Ave

15 Filed, 7 1927, 19 .... C. HAMPSON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1927, to July 26, 1927
that I last saw h alive on July 25, 1927
and that death occurred, on the date stated above, at 1 A. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.
1927 (Address) 4 W. Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: June 28 19 27

20 UNDERTAKER: H. A. Reinhardt Son — ADDRESS: Balto Md

Spec—12-23-21—E.P.R.S.—400 Bks.

E 24255

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24255

CERTIFICATE OF DEATH.

57

15-67

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3007 Ridgewood St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Preston Riddle

(a) Residence No. 3007 Ridgewood St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lillian E. Jackson

6-DATE OF BIRTH (month, day and year) Mar 26 62

7-AGE. 65 yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Printing

(b) General nature of industry, business, or establishment in which employed (or employer)..... General printing

(c) Name of employer..... Self

9-BIRTHPLACE (city or town)..... (State or Country). Chestertown Md.

PARENTS:

10-NAME OF FATHER, Levi Riddle

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Mary E. Newell

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Md

11- (Informant) Lillian E Riddle

(Address) 3007 Ridgewood

15-

Filed ..... 192 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 25-1927

17- I HEREBY CERTIFY, That I attended deceased from Sept 30 1922 to July 25 1927

that I last saw him alive on July 25 1927

and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 5 yrs. mos. ds

CONTRIBUTORY (Secondary) Cerebral oedema + Cardiac insufficiency (Duration) yrs. 3 mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H E Krotz M. D

July 26, 1927 (Address) 4025 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, ... 19
Druid Hill	July 28 19 27
20-UNDERTAKER Wm J Jackson-Sons	ADDRESS [illegible]

JUL 27 1927 C. HAMPSON JONES, M. D.

RPH

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24256

E 24256

CERTIFICATE OF DEATH.

Pronounced dead @ 4-26 74-001 V

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. @ Franklin Sq. St. No. 2 Ward)

2-FULL NAME Thos. P. Minshall.

(a) RESIDENCE NO. 945 W. Franklin St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie C. Minshall

6 DATE OF BIRTH (month, day, and year): May 22nd 1864

7 AGE: Years 63 Months 2 Days 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Collector

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Home Friendly

9 BIRTHPLACE (city or town):

(State or country): Ohio

PARENTS

10 NAME OF FATHER: Presley K. Minshall

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ohio

12 MAIDEN NAME OF MOTHER: Elizabeth Joyce

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Annie C. Minshall

(Address) 945 W. Franklin St.

15 Filed ..... 19 ..... Registrar

1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an (inquest, autopsy or inquiry.) thereon and from the evidence obtained by me and ..... (inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

July 26 1927 (Signed) H. B. Norris M. D. Coroner

(Address) Curtis Bay

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See instructions on back for particulars required in violent deaths.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial: July 28 1927

20 UNDERTAKER: Geo. W. Lutte ADDRESS: 22 Edmondson

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24257

CERTIFICATE OF DEATH

75-002 V

E 24257

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert MacKertie

(a) RESIDENCE NO. 828 N. Carey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 31 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work disabled war Veteran

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fitzgerald (State or country) Ga.

PARENTS

10 NAME OF FATHER Alex MacKertie.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Memmie Douglas.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Rev. Garnet Lyons.
(Address) 828 N. Carey St

25 Filed ..... 19 .....
Registrar

Per Rock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-18 1927 to 7-25 1927

that I last saw him alive on 7-25 1927,

and that death occurred, on the date stated above, at 7:45 p m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia, Paralysis Sphincter of Bladder, rectum, Paralysis lower extremities, Bladder, rectum, Hopeless ulcers back & hips (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exposure to synovial cord in war, Fistula duodenum. (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? in army

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. L. Jackson, M. D.

(Address) 1/25 1927 1501 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery. Date of Burial July 25 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 393 Preston

Very Important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24258 123 E 24258

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 819 S Potomac St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Raynor

(a) RESIDENCE NO. 819 S Potomac St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry M Raynor

6 DATE OF BIRTH (month, day, and year): June 14 1877

7 AGE — Years: 50 — Months: 1 — Days: 12

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Co

PARENTS

10 NAME OF FATHER: Jessie Jackson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Susan Updegraff

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Howard Co

14 Informant (Address): Mary M Raynor 819 S Potomac

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1927

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1927, to July 26, 1927.

that I last saw h.. alive on July 26, 1927,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Biliary Calculi

(duration) yrs. 2 1/2 mos. ds.

18 Where was disease contracted if not at place of death? L

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Grant A. Glentz, M. D.

July 27, 1927 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — Date of Burial: July 28 1927

20 UNDERTAKER: William Cahill — ADDRESS: 502 E North Ave

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24259

CERTIFICATE OF DEATH

E 24259

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1528 E. Pratt St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arnold Lee Hong

(a) RESIDENCE NO. 1528 E. Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Chinese White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 23 1924

7 AGE: Years 2 Months 11 Days 4 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Ku Hong

11 BIRTHPLACE OF FATHER (City or town)

(State or country): China

12 MAIDEN NAME OF MOTHER: Shee Wong

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): China

14 Informant: Ku Hong

(Address): 1528 E Pratt St.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 19 27 to July 27 19 27

that I last saw h[illegible] alive on June 19 27

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 3 mos. 1

CONTRIBUTORY (Secondary) Congenital weakness

Pneumonia (duration) 2 yrs. 11 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pneumonia

(Signed) [illegible] M. D.

7/27 1927 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. Date of Burial July 28 1927

20 UNDERTAKER: John O Mitchell ADDRESS 1900 Eutaw Pl.

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24260

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24260

CERTIFICATE OF DEATH

X 23

1-PLACE OF DEATH

REGISTERED NO. 16-37

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward (SCHLEIBAUM)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Schlenglebaum

(a) RESIDENCE NO. 1519 N. 61 St. Philadelphia Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) May 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	32	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER A. L Schleibaum

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ? Germany

12 MAIDEN NAME OF MOTHER Louise Butchaveid

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ? Germany

14 Informant

(Address) Records

15 Filed ..., 19... Registrar RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24/1927.

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1927, to July 24, 1927,

that I last saw him alive on July 24, 1927

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY Pulmonal Tuberculosis

(Secondary)

encephalitis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General & Sect.

(Signed) C. Hampson Jones, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL 1st Evangelical Cemetery — Date of Burial July 28 1927

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS 1710 Fleet St.

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24261

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24261

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH 38 S. Curley St.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 1-2 WARD)

2-FULL NAME Elizabeth Baker

(a) RESIDENCE NO. 38 S. Curley St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. ..... mos. 22 ds. How long in U. S., if of foreign birth? life yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Baker

6 DATE OF BIRTH (month, day, and year) July 4, 1851

7 AGE — Years 76 — Months 0 — Days 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Paul Brehm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Lausch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Margaret Gardner

(Address) 38 S. Curley St.

15 Filed ..... 19 27 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 8 19 27 to July 26 19 27.

that I last saw h[illegible] alive on July 26 19 27.

and that death occurred, on the date stated above, at 2.45 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Nephritis, hypertension

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. C. Sobieraj, M. D.

19 (Address) 447 N. Lemmon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL July 29, 1927

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS 1710 Fleet St.

Spec.—12-9-25—A Co.—200 Bks.

E 24262

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-201

E 24262

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1917 Etting St. 1420 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Boston

(a) RESIDENCE NO. 1917 Etting St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27 1927

7 AGE: Years | Months | Days | IF LESS than 1 day 3 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Joseph A Boston

11 BIRTHPLACE OF FATHER (city or town) Cambridge

(State or country) Md

12 MAIDEN NAME OF MOTHER Susie Moody

13 BIRTHPLACE OF MOTHER (city or town) Easton

(State or country) Md

14 Informant Joseph A Boston

(Address) 1917 Etting

C. THAMPSON JONES, M. D.

15 Filed ..., 19...

Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1927

17

I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,

that I last saw h... alive on July 27, 19 27,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

7-27 1927 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cem. Date of Burial 7-28 1927

20 UNDERTAKER: George T. A. Gibson ADDRESS 1735 Druid Hill Ave

very important. See instructions on back of certificates.

Spec.—1-10-21—M—1—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24263

CERTIFICATE OF DEATH.

113 E 24263

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1215 Carey ST. 7-27 WARD)

2-FULL NAME Violet Ruth Howes

(a) RESIDENCE NO. 1215 Carey ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): January 8-1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	1	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Harold Howes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Edith Marriott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Harold Howes
(Address): 1215 E Carey St

15 Filed JUL 28 1927, 19 C. HAWKINS RICE M.D. Registrar: [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/26/1927

17 I HEREBY CERTIFY, That I attended deceased from 7/24/1927 to 7/26/1927

that I last saw her alive on 7/26/1927

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Marked

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Matthew A Dawson, M. D.

7/27 1927 (Address) 17 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendship Cem

DATE OF BURIAL: July 28 1927

20 UNDERTAKER: Wm J Tuckner Sons

ADDRESS: N. Va

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24264

CERTIFICATE OF DEATH

REGISTERED NO. E 24264

1-PLACE OF DEATH — University Hospital

City of BALTIMORE: (No. Lombard and Greene St., 27-55 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Snyder

(a) RESIDENCE NO. 436 Rockwood St. Arlington Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4, 1904

7 AGE Years 22 Months 8 Days 22 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Water Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer State Road

9 BIRTHPLACE (city or town) Baltimore Maryland

(State or country)

PARENTS

10 NAME OF FATHER Frank Snyder

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J Brady

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant James C Slatter

(Address) 5 Church Lane Pikesville

15 Filed JUL 28 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1927, to July 26, 1927, that I last saw him alive on July 26, 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Tetanus

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Crushing injury to left foot

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? — Not Known

Did an operation precede death? Yes Date of 7/21/27

Was there an autopsy? — Yes

What test confirmed diagnosis? Clinical course

(Signed) Charles E Hall M. D.

July 26 1927 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Charles Pikesville — Date of Burial July 29 1927

20 UNDERTAKER Wm Cooke — ADDRESS 502 E North Ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks. Dr Jones 1744 N Rond Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24265 — CERTIFICATE OF DEATH. — 10-002 E 24265

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1612 Ruxton Ave ST.) 15-68 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian M Eisenhart

(a) RESIDENCE NO. 1612 Ruxton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 13. 1922

7 AGE — Years: 5 — Months: 4 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis D Eisenhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Lillian Yager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Lillian D Eisenhart (Address) 1612 Ruxton Ave

15 Filed JUL 28 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1927

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1927, to July 27, 1927, that I last saw he alive on July 26, 1927 and that death occurred, on the date stated above, at 6 am

The CAUSE OF DEATH* was as follows:

Diphtheria

Myocarditis

Acute Heart Failure

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Petechiae Spots on Body

amal admit (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? I dont Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? H-D. Laboratory

(Signed) Chas Jones, M. D.

, 19 (Address) 1744 N Monroe ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 28 1927

20 UNDERTAKER: H. Cook — ADDRESS: 2212 Madison

HARRISON JONES, M.D.

Spec. 12-23-21—E.B.R.S.—400 Bks.

Guarino

HEALTH DEPARTMENT—CITY OF BALTIMORE

24266

CERTIFICATE OF DEATH.

16 E 24266

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1221 W Mathias St., 14-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Rubinda Guarino

(a) Residence No. 1221 W. Mathias ave St., Ward.....
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 17 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): July 12 27

7-AGE. If LESS than 1 day, ... hrs. or ... min.?

... yrs. ... mos. 14 ds.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: ———

(b) General nature of Industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS

10-NAME OF FATHER: Alphonse G.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md Balto

12-MAIDEN NAME OF MOTHER: Minnie Souza

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Honolua

14-

(Informant): Alphonse Guarino

(Address): 1221 W North

15-

Filed ... 192 ... Registrar.

C. HAMPSON JONES, M. D.

JUL 28 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 26/27

17- I HEREBY CERTIFY, That I attended deceased from July 12 1927 to July 26 1927

that I last saw her alive on July 26 1927

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Haemorhagic Disease of New Born

(Duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Stated M. D.

July 27. 1927 (Address) 190 E. Mathias

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimoral Cemetery	July 28. 1927
20-UNDERTAKER.	ADDRESS
W M Coulson	2235 W Mathias

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24267

CERTIFICATE OF DEATH.

46 E 24267

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 840 Konig St. 13-54 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Fox

(a) RESIDENCE NO. 840 Konig St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S. if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Fox

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Bennet

11 BIRTHPLACE OF FATHER (City or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rua Rosman

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Russia

14 Informant (Address) Louis Bennet 840 Konig St

15 Filed JUL 28 1927 F. H. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 19 27

17

I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1926, to July 25, 1927, that I last saw her alive on July 25, 1927, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of body of Uterus, Sigmoid and Rectum

(duration) yrs. 9 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 16 1927

Was there an autopsy? no

What test confirmed diagnosis? operation - clinical

(Signed) R. G. Nicholson, M. D.

(Address) 2230 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	July 29 19 27

20 UNDERTAKER Jack Levin ADDRESS 1439 Eutaw St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24268

CERTIFICATE OF DEATH.

16 E 24268

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. University Hospital St., 18-N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Fitzgerald

(a) Residence No. 843 W. Lexington St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black.

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 7/24/27.

7-AGE. ..... yrs. ..... mos. 1 ds. If LESS than 1 day, 3 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Leroy Eden

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Vera Thelma Fitzgerald

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Brunswick Co. Va.

14- (Informant) .....

(Address) .....

15- Filed ..... 192 ..... Registrar.

C. HAMILTON JONES, M. D.
UNIVERSITY OF MARYLAND

2-8-1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 7/25/27.

17- I HEREBY CERTIFY, That I attended deceased from 4/24/27, 19 ..... to 7/25/27, 19 .....

that I last saw h living alive on 7/25/27, 19 .....

and that death occurred, on the date stated above, at 1.50 p.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

.....

.....

.....(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Geo. T. Hobbs, M. D.

, 19 (Address) Community Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL, ...

20-UNDERTAKER, UNIVERSITY OF MARYLAND ADDRESS UNIVERSITY OF MARYLAND

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24269

CERTIFICATE OF DEATH.

E 24269

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 S. Clinton St. ST. 76-2 WARD)

2-FULL NAME Benjamin Huber

(a) RESIDENCE NO. 611 S. Clinton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Huber

6 DATE OF BIRTH (month, day, and year): June 8 1883

7 AGE: Years 44 Months 1 Days 18 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore County

PARENTS

10 NAME OF FATHER: Anthony Huber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rose Sinclair

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Daniel Huber

(Address): East End

15 Filed ... 19 ... Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 . 1927 . to July 26 . 1927 .

that I last saw him alive on July 26 . 1927

and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach Liver and Complications

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of Jan. 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J. Schmidtlein M. D.

, 19 (Address) 45 14 Eastern Ave - City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cem

DATE OF BURIAL: July 29 1927

20 UNDERTAKER: George W. Zirkler

ADDRESS: 1737 E. Eager St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 24270
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

× 43E 24270

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Howard A Kelly Hospital 1419 Eutaw Place ST. 14-20 WARD)

2-FULL NAME Mrs. Harrison Scott.

(a) RESIDENCE No. 1431 L St. N.W. Washington, D.C.
(Usual place of abode) ST., WARD

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
about 60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Newspaper. 18th

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed ..... 19 .....
JL 26 1927 C. HAMPSON JONES, M. D.
Registrar
Per RHK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to July 28, 1927,
that I last saw him alive on July 28, 1927,
and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Tonsil.

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) —
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Microscopic

(Signed) John B. Hopkins M. D.

1/28, 1927 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington, Pa — DATE OF BURIAL 7/28 1927

20 UNDERTAKER Wm. J. Dickson & Sons — ADDRESS Pa. North

Spec.–7-17-26—A Co.—200 Bks.

Mary G. Neal (Robertson) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24271

CERTIFICATE OF DEATH

44 E 24271

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St. Joseph's Hosp. St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Grace Neal (Roberson)

(a) RESIDENCE NO. 501 N. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 5 mos. 28 ds. How long in U. S. if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widowed

6 DATE OF BIRTH (month, day, and year): January 29 1871

7 AGE: Years 56 Months 5 Days 28 IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. (State or country): Md

PARENTS

10 NAME OF FATHER: George H. Patterson

11 BIRTHPLACE OF FATHER (City or town): (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary E. Harrison

13 BIRTHPLACE OF MOTHER (city or town): (State or country):

14 Informant: Mrs. Kate M. Stein

(Address) 2423 E. Pratt St.

15 Filed ... 19... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/20, 1927, to 7/26/, 1927,

that I last saw h[illegible] alive on 7/26/, 1927,

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Neoplasm of abdomen.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Dilatation of heart

(duration) yrs. mos. 14 ds.

18 Where was disease contracted?

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Lawrence Gahrmann, M. D.

July 27, 1927 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: July 29 1927

20 UNDERTAKER: Henry Hoech Son — ADDRESS: 134 E. Eager St.

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 24272

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

129 E 24272

REGISTERED NO.

City of BALTIMORE: (No. 9th St & 3rd Ave. Fairfield. 25-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Jenushat.

(a) RESIDENCE NO. 9th St & 3rd Ave. Fairfield. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, HUSBAND of XXXXXXXXXXXX Augusta Jenushat

6 DATE OF BIRTH (month, day, and year) October 29, 1849.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do nog know.

14 Informant Augusta Jenushat.(wife)

(Address) 9th St & 3rd Ave. Fairfield.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquest found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

7/27 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Cedar Hill Cem. — Date of Burial Jul 28 1927

20 UNDERTAKER — E & B Hall — ADDRESS 115 E. Mulb

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24273

E 24273

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1923 - Hope St. St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine McGinn.

(a) RESIDENCE NO. 1923 - Hope St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John McGinn

6 DATE OF BIRTH (month, day, and year) 4/24/1850

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	76	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Martin Lotz

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Thomas Ruter

(Address) 1923 - Hope St

15 Filed JUL 28 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUL 27 1927

17 I HEREBY CERTIFY, That I attended deceased from JUN 18 1927, 19, to JUL 27 1927, 19.

that I last saw h[illegible] R. alive on JUL 27 1927, 19.

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

[illegible] Cardiac Dilatation probable

Carcinoma

(duration) X yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Gall stone infection

(duration) 20 yrs. X mos. X ds.

18 Where was disease contracted

If not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None only clinical symptoms

(Signed) D. H. Duker M. D.

JUL 28 1927 (Address) 928 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmell — Date of Burial 7 30 1927

20 UNDERTAKER Geo. J. Rutle — ADDRESS 1731 Harford

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24274

CERTIFICATE OF DEATH.

X 167 ✓ E 24274

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 815 Warner St. 21-31 St. _____ Ward)

2-FULL NAME Joseph Green.(C)

(a) RESIDENCE NO. 815 Warner St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Married.

5a If married, HUSBAND of XXXXXXXXXXXX Celesta Green.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31	---------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labofer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Ella Johnson.(C) cousin.

(Address) 815 Warner St.

15 Filed _____, 19__ (C. HAMPSON JONES, M. D.) Registrar

THE MORGUE. 24274

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Over dose of Ether.
Suicide,

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) [illegible] M. D.
(Coroner)

7/25 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY, Date of Burial JUL 27 1927 19

20 UNDERTAKER Commissioner Health, ADDRESS

Dep. Wm. H. WORNALL

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Weaver

Cor.—12-9-25—A Co.—200 Bks.

Weaver

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24275

E 24275

CERTIFICATE OF DEATH. 192

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 22-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eddie Weaver

(a) RESIDENCE NO. 515 Burgundy St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1895

7 AGE — Years: 32 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): General

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed....., 19.....

Per BPA Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.)

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ....., M. D.

(Coroner)

....., 19.... (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs., ... mos., ... ds. In the State..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY. Date of Burial 19

20 UNDERTAKER ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24276

CERTIFICATE OF DEATH.

188-002

E 24276

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-37 Ward)

2-FULL NAME Dusan Razumenics

(a) RESIDENCE NO. Unknown St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 45 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above; held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au- (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st Car Acc

Multiple fractures

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

July 20 1927 (Signed) G C Ladas M. D.

(Coroner)

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY Date of Burial JUL 27 1927 19

20 UNDERTAKER [illegible] ADDRESS

Very Important. See instructions on back of certificate.

CHAMPION JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24277 ✓

E 24277

CERTIFICATE OF DEATH.

1927

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. Mercy Hosp St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Andrews

(a) RESIDENCE NO. 1043 N. Hilton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 60 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed 1927 G. HAMPSON JONES, M. D.,

28 1927 Per RKH Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Short while (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

July 26 (Signed) ..... M. D.
(Coroner)

, 1927 (Address) 1032 Bennett Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 4 yrs., mos., ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY. | Date of Burial 19

20 UNDERTAKER | ADDRESS

Very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24278

CERTIFICATE OF DEATH

38 E 24278

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Providence Hospital St., 17-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Thomas

(a) RESIDENCE NO. 735 Bradley St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14(?) ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days
			14(?)

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant

(Address)

15 Filed ....., 19..... Registrar

THE MORGUE.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1927

I HEREBY CERTIFY, That I attended deceased from July 8, 1927, to July 10, 1927, that I last saw h.. alive on July 9, 1927, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows: Malnutrition & Mal-developement.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uncertain probably Lues.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 735 Bradley St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) John W. Gardner, M. D.

, 19 (Address) Providence Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

Date of Burial JUL 27 19

20 UNDERTAKER C. HAMPSON JONES, M. D. Commissioner of Health

ADDRESS

28 1927

RPH

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 24279

HEALTH DEPARTMENT—CITY OF BALTIMORE

43 E 24279

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

City of BALTIMORE: (No. ____ St., 76-37 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Richards

(a) RESIDENCE NO. 4819 Eastern Ave St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N Y

(State or country)

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (city or town)

(State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) " "

14 Informant Patient

(Address) UNIVERSITY OF MARYLAND

15 Filed ____ 19 ____ Registrar

1575 RPB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-12, 1927, to 7-26, 1927, that I last saw him alive on 7-26, 1927, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? Yes Date of 7/25/27.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L. Dalaglacca M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ____ Date of Burial ____ 19

20 UNDERTAKER ____ ADDRESS ____

Commissioner Health.

JUL 28 1927

per Wm. T. RUSSELL

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24280

CERTIFICATE OF DEATH

129

E 24280

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1729 Pennington Ave 25-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard B Chalker

(a) RESIDENCE NO. 1729 Pennington Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella M Chalker

6 DATE OF BIRTH (month, day, and year): Dec 7/1850

7 AGE: Years 76 Months 7 Days 20

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: U S Chem. Co

(b) General nature of industry, business, or establishment in which employed (or employer): Shipping Dept 86

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Mich.

PARENTS

10 NAME OF FATHER: A. B. Chalker

11 BIRTHPLACE OF FATHER (City or town)

(State or country): New York

12 MAIDEN NAME OF MOTHER: Georgia Judd

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): New York

14 Informant: Ella M Chalker

(Address): 1729 Pennington Ave

15 Filed , 19 Registrar

C. HAMPSON JONES, M. D.

1927 Per RPP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to July 27, 1927.

That I last saw h[illegible] alive on July 26, 1927.

and that death occurred, on the date stated above, at 6.20 a. m.

The CAUSE OF DEATH was as follows: -

Arterio-Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas F Brooke, M. D.

, 1927 (Address) Brooklyn Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Binghamton N. Y. Date of Burial: Jul 29 1927

20 UNDERTAKER: Wm Lockard ADDRESS: 526 North Ave

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Letter and file dated Aug 2-1927 from C. H. Boyd, M.D. for Correction of age

E 24281

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24281

100-00

CERTIFICATE OF DEATH

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 27-48

City of BALTIMORE: (No. [redacted] St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Seward.

(a) RESIDENCE NO. 6007 Brady Drive Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? unknown

7 AGE: Years 65 Months Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER ? unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ? unknown.

12 MAIDEN NAME OF MOTHER ? unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ? unknown.

14 BALTIMORE CITY HOSPITALS

Interment

(Address) Reisterstown.

15 Filed AUG 2 8 1927, 19 C. HUMPSON JONES, M. D. Registrar

Per RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1927, to July 26, 1927,

that I last saw her alive on July 26, 1927,

and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia -

bilateral.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Scalp

(Signed) C. Hampson Jones, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Grave.

Date of Burial 7/29/27 19

20 UNDERTAKER: Mary M. Wiedefeld.

ADDRESS [redacted]

5 of 225

Keep this record of certificates. Very important. See instructions on back of

Spec—12-23-21—E.B.R.S.—400 Bks.

E 24282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 24282

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 524 N. Kenwood Ave St., 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Sophia Momberger .....

(a) Residence No. 524 N. Kenwood Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~Single~~ ~~Married~~ ~~Widowed~~ ~~Divorced~~ (Write the word.)
female	white	widowed

5a-If ~~married~~ widowed, ~~or husband of~~ WIFE of Adam Momberger

6-DATE OF BIRTH (month, day and year) Jan. 30. 1858

7-AGE.	If LESS than 1 day.
69 yrs. 5 mos. 26 ds.	....hrs. or.....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frederick Detkin

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Christina Fauldrath

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant)..... Mr. Momberger (Son)
(Address)..... 524 N. Kenwood Ave

15- Filed..... 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 26, 1927

17- I HEREBY CERTIFY, That I attended deceased from June 23-27 19.. to July 26 19 27.

that I last saw h... alive on July 26- 19 27

and that death occurred, on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(Duration)..... yrs. 6 mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. 6 mos..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Frederick D. Hammann M. D.

July 28- 27 (Address) 2913 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Emanuel Cemetery	July 29. 1927
20-UNDERTAKER	ADDRESS
Hughes & Jones Inc	424 N. Broadway

JUL 28 1927

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24283 E 24283

CERTIFICATE OF DEATH.

124

1 PLACE OF DEATH

City of BALTIMORE: (No. ~~East~~ 912 Hanover St. 7-31 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara M. Mullis

(a) Residence No. 912 Hanover St St., Ward

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widow, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Mullis

6-DATE OF BIRTH (month, day and year): Nov 26th 1845

7-AGE: 81 yrs. 8 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer:

9-BIRTHPLACE (city or town), (State or Country): Baltimore

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town), (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town), (State or Country): Germany

11- (Informant): Mrs Mary Seitz

(Address): 913 Hanover St

15- Filed ... 19... C. HAMPSON JONES, M. D. Registrar.

AUG 8 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 7.28.27.

17- I HEREBY CERTIFY, That I attended deceased from 4.5.27. to 7.28.27. that I last saw h[illegible] alive on 7.27.27. and that death occurred, on the date stated above, at 12.20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical - microscopic chemical.

(Signed) Philip B. Fowler M. D.

7.28.27 (Address) 1482 William St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn Cem.	July 30th 1927
20-UNDERTAKER, E. Schumacher Son	ADDRESS 1034 Hanover St

Spec.-7-17-26—A Co.—200 Bks.

E 24284

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

109-002

E 24284

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Iva May Koons

(a) RESIDENCE NO. Taneytown, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mr. M. A. Koons

6 DATE OF BIRTH (month, day, and year) May 22, 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	53	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Detour

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Weant

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Fred. Co. Md.

12 MAIDEN NAME OF MOTHER Hannah Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Fred. Co.

14 Informant Hospital Record,

(Address)

15 Filed ..... 19 ..... Registrar

AUG 8 1927 C. HAMPSON JONES, M. D. Dep't

RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1927, to 7-28, 1927, that I last saw her alive on 7-28, 1927, and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcic Viridans Throat

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Septic Broncho Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Test.

(Signed) Jno. B. Gantt M. D.

. 19 (Address) Md Gulden Arms.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means, and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Reformed Taneytown Md July 31 1927

20 UNDERTAKER — ADDRESS

C O Bussard Son Taneytown Md

Very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

24285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24285

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1903 W. Baltimore St. 20-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Caroline Mahle

(a) RESIDENCE NO. 1903 W. Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. ✓ mos. ✓ ds. How long in U. S. if of foreign birth? 74 yrs. ✓ mos. ✓ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married~~ widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Jacob Mahle

6 DATE OF BIRTH (month, day, and year): Sept 27 - 1838

7 AGE: Years 88 Months 10 Days ✓

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer ✓

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER — Schwartz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER — Bowman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant: C. H. Mahle

(Address) 1903 W. Baltimore St

15 Filed ... 19 ...

28 1927

NRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 27-1927.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1924 to July 27, 1927,

that I last saw h[illegible] alive on July, 1927,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Paresis

(duration) 2 yrs. 8 mos. ✓ ds.

CONTRIBUTORY (Secondary) Senility — Arteriosclerosis.

(duration) 2 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted ✓

if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) Geo. E. Shannon, M. D.

7/28. 19 27 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

Date of Burial: July 30 1927

20 UNDERTAKER: Sept 18 Cook

ADDRESS 1003 W. Balto St

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24286

CERTIFICATE OF DEATH

122-90 ✓ E 24286

REGISTERED NO. 20-69

1-PLACE OF DEATH

City of BALTIMORE: (No. 2502 W. Baltimore St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Bates

(a) RESIDENCE NO. 2502 W. Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 21, 1861

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Bates

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Seltzer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Miss Amelia Bates

(Address) 2502 W. Baltimore St.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to July 16, 1927, that I last saw him alive on July 16, 1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the liver (alcoholic)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted dont know ✓ ✓

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A Keller Hennessy M. D.

(Address) 2000 Hollins St.

7/27/27

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — Date of Burial 7/27/27 19

20 UNDERTAKER Joseph B Cook — ADDRESS 1002 W. Baltimore St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24287

CERTIFICATE OF DEATH.

X 74-00

E 24287

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 25-74 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Alexander Coursey.

(a) RESIDENCE NO. Halethorpe Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. 1 mos 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Ann Smith

6 DATE OF BIRTH (month, day, and year): November 27, 1844

7 AGE: Years 82 | Months 8 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Co.,

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Wesly B. Coursey

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Jane Harper

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant (Address): Mr. Alexander S. Coursey Halethorpe, Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1927

17 I HEREBY CERTIFY, That I attended deceased from May 31 1927, to July 27, 1927, that I last saw h[redacted] alive on July 27, 1927 and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. 2 mos. ..... ds.,

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Willard Spence, M. D.

July 28 1927 (Address) Halethorpe, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lansdowne, Md. Date of Burial: 7/30/27

20 UNDERTAKER: Joseph B Cook ADDRESS: 1005 W. Baltimore St

C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24288

CERTIFICATE OF DEATH

REGISTERED NO. E 24288

1-PLACE OF DEATH

City of BALTIMORE (Co. University Hospital St. 1130 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Catherine Streaker

(a) RESIDENCE NO. Ellicott City Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Streaker

6 DATE OF BIRTH (month, day, and year) Aug 15th 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hampstown Md.
(State or country)

PARENTS

10 NAME OF FATHER John W. Walker

11 BIRTHPLACE OF FATHER (City or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Cutsail

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Charles Streaker
(Address) Ellicott City Md.

15 Filed , 19 C. HANSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/29 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/27 1927 to 7/29 1927 that I last saw h[illegible] alive on 7/29 1927 and that death occurred, on the date stated above, at 2:00 A.m.

The CAUSE OF DEATH* was as follows:

Emphysema of Gall Bladder

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute Oedema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted 6 hours - if not at place of death? Ellicott City

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Louis Aloysius Layton M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Cem. Date of Burial July 31 1927

20 UNDERTAKER [illegible] ADDRESS [illegible]

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24289

CERTIFICATE OF DEATH.

113 E 24289

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 147 W. Hamburg St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Rhoades

(a) RESIDENCE NO. 147 W. Hamburg St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 12-2-1926

7 AGE — Years: | Months: 7 | Days: 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md

PARENTS

10 NAME OF FATHER: Aaron Rhoades

11 BIRTHPLACE OF FATHER (city or town):

(State or country): N.C.

12 MAIDEN NAME OF MOTHER: Harriet Boyd

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Harriet Rhoades

(Address) 147 W. Hamburg St

15 Filed _____ 19____ Registrar

JUL 29 1927 6 HAMDEN JONES M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1927, to July 27, 1927, that I last saw him alive on July 27, 1927, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) ___ yrs. ___ mos. 4 ds.

CONTRIBUTORY (Secondary): None

(duration) 8 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ___

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. A. Kirwin, M. D.

, 19___ (Address) 801 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial: 7-29 1927

20 UNDERTAKER: John H. Trodevin — ADDRESS 1027 Hanover

Very Important: See Instructions on Back of Certificate.

Cor.--12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24290

CERTIFICATE OF DEATH.

18-002

E 24290

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1008 N. Carrollton Ave St., 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Long

(a) RESIDENCE NO. 1008 N. Carrollton Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Long.

6 DATE OF BIRTH (month, day, and year) June 6 1900

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	27	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer General

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER John W Matthews

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E Smith

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Md

14 Informant Mary E Smith

(Address) 1008 N Carrollton Ave

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) E. E. Kenney M. D.
(Coroner)

July 27 19 27 (Address) 1807 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Date of Burial July 29 1927

20 UNDERTAKER Franklin W Seyf ADDRESS 709 W 38 St

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24291

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Eastern ave ST. 13 WARD)

2-FULL NAME Infant. Skopp

(a) RESIDENCE No. 2116 Eastern Ave ST. ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

REGISTERED NO. 161 E 24291
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or Dmin
7 Hours			1 day	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Wallie Skopp
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md
12 MAIDEN NAME OF MOTHER Mary Albrecht
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wallie Skopp
(Address) 2116 Eastern ave

15 Filed ..... 19 ..... Registrar
C. HAMPTON JONES, M. D.
Pd: RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1927, to July 29, 1927, that I last saw h[illegible] alive on July 28, 1927, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Premature delivery,

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Asthenia & Heart failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ray A Brodrick ....., M. D.

, 19 (Address) 1623 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary July 29 1927

20 UNDERTAKER F. W. Ozazewski ADDRESS 1930 Eastern ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24292

CERTIFICATE OF DEATH.

E 24292

REGISTERED NO.

1-PLACE OF DEATH Found in West. Md. R. R. Yard. 27

City of BALTIMORE: (No. ____ St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Meyer Goldberg

(a) RESIDENCE NO. Hebrew Home for the aged St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE — Years: 75 — Months: ____ — Days: ____ — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired Haydealer

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town): ____

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town): ____

(State or country) Russia

14 Informant Jack Levis

(Address) 1439 Eastern Ave

15 Filed ____ G. HAMILTON JONES, M. D. Registrar

Per ____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(duration) ____ yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) no other history.

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

(Address) 2802 Edmondson Ave

July 29 19 27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the state ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Int. Corned — Date of Burial 7/29 19 27

20 UNDERTAKER: Jack Levis — ADDRESS 1439 Eastern Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24293

CERTIFICATE OF DEATH.

49 ✓

E 24293 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 13-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Kramer

(a) RESIDENCE NO. 821 Mewington Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: X

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Kramer

6 DATE OF BIRTH (month, day and year): Unknown

7 AGE: Years 45 | Months — | Days — | *IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER: Lark Chor

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Louis Kramer

(Address): 821 Mewington Ave

15 Filed JUL 29 1927 19 RMC Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 July - 29 -

17 I HEREBY CERTIFY, That I attended deceased from July - 22 - 1927, to July 29 - 1927, that I last saw her alive on July - 29 - 1927, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure -

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of July-25-27

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) Edward J. Steelman M. D.

7-29, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rural 6/24 Date of Burial 19 27

20 UNDERTAKER: Jack Levis ADDRESS 1439 Eastern Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24294

23 E 24294

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No. 13-29 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Bolton

(a) RESIDENCE NO. 2204 Bryant Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anne Bolton

6 DATE OF BIRTH (month, day, and year) 25-1893

7 AGE: Years 33 Months 7 Days 3

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Aaron Bolton

11 BIRTHPLACE OF FATHER (City or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Isah Tritolski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jacob Bolton 2204 Bryant Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 July 28

17 I HEREBY CERTIFY, That I attended deceased from July 5 1927 to July 28 1927 that I last saw h living on July 25 1927 and that death occurred, on the date stated above, at 1:45P m.

The CAUSE OF DEATH* was as follows:

Exacerbation of chronic Lobar Pulmonary tuberculosis

Being treated with malaria

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lewis Aldo Taynton M. D.

7/28 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northern Avenue

Date of Burial July 29 1927

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eutaw

Per K.K.

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24295

CERTIFICATE OF DEATH.

162 E 24295

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 15-58 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Sherman

(a) RESIDENCE NO. 2301 Tioga Place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	White (Jewish	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
July 27 - 1927

7 AGE	Years	Months	Days	IF LESS than 1 day 20 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. (M)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Eli Sherman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Anna Levin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Hosp. Records

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

7-28-27

17

I HEREBY CERTIFY, That I attended deceased from 7-27, 19 27, to 7-28, 19 27, that I last saw h[illegible] alive on 7-28, 19 27, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Wm Schaman, M. D.

7-28-1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Hebrew Rel Carmel 7/29 1927

20 UNDERTAKER ADDRESS

Jack Levin 1839 E Balt St

Spec.—1-10-21—M&T—1500 Blks.

E 24296

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24296

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2646 Oswego Ave St., 15-58 WARD) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Brigida Vazzana

(a) RESIDENCE No. 2646 Oswego Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Santo Vazzana

6 DATE OF BIRTH (month, day, and year): Oct 3. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Nunzio Greco

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosa Fava

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Vincent Greco

(Address) 2646 Oswego ave

15 Filed 23 1927 . 19 C. HAMILTON JAMES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1927

17

I HEREBY CERTIFY, That I attended deceased from July 1 . 1927 . to July 27 . 1927 .

that I last saw her alive on July 27 . 1927 .

and that death occurred, on the date stated above, at 5 15 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Aortic Insufficiency

Mitral Insufficiency

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George B Brief, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: July 30th 197

20 UNDERTAKER: Frank V. Pipitone

ADDRESS: 2818 E. Baltimore st

Spec—12-23-21—E.B.R.S.—400 Bks.

E 24297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24297

1-PLACE OF DEATH

City of BALTIMORE: (No. 1312 Argyle Ave. St. 17-24 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Unknown

(a) Residence No. 1312 Argyle Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 7/28/27

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or. 15 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) 1312 Argyle Ave (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Unknown (State or Country),

12-MAIDEN NAME OF MOTHER, Irene Melvin

13-BIRTHPLACE OF MOTHER (city or town) Emmitsburg (State or Country), Md.

14- (Informant) Hosp. Records

(Address)

15- Filed, 2 1927 19 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/28/27

17- I HEREBY CERTIFY, That I attended deceased from 4/28/27 19 to 7/28/27 19

that I last saw h alive on 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. T. Hobbetts M. D.

, 19 (Address) Mercy Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Greenmount Cem.	7/30/27 19

20-UNDERTAKER. ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24298
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74-001

E 24298
REGISTERED NO.

City of BALTIMORE: (No. 321 E Barclay St 12-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zekuciel George

(a) RESIDENCE NO. 321 E Barclay St. 12 Ward
(usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 13, 1884

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS

10 NAME OF FATHER Gilbert Grice

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Newborn N. C.

12 MAIDEN NAME OF MOTHER Louisa Macoren

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Gilbert Grice
(Address) 321 E Barclay St.

15 Filed JUL 29 1927 19 A.M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry)
find that said deceased came to death
on the day stated above.
The CAUSE OF DEATH was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) High Blood Pressure

(duration) yrs. mos. ds.

(Signed) Chas J Hammen, M. D.
(Coroner)

7/28 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial July 29 27

20 UNDERTAKER Mrs J G. Locks ADDRESS 1302 Jefferson

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24299

CERTIFICATE OF DEATH.

161-001

E 24299
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2519 FOSTER AVENUE St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant LIPINSKI

(a) RESIDENCE NO. 2519 FOSTER AVENUE St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: FEMALE

4 Color or Race: WHITE

5 Single, Married, Widowed, or Divorced. (write the word)

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) JULY 28, 1927.

7 AGE — Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Benjamin Lipinski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Zegarowicz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mother, Anna Zegarowicz

(Address) 2519 Foster Avenue

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 28, 1927

17

I HEREBY CERTIFY, That I attended deceased from July 28- 19 27, to July 28- 19 27, that I last saw her alive on July 28-1927 19, and that death occurred, on the date stated above, at 12;noon m.

The CAUSE OF DEATH* was as follows:

premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Date of

Was there an autopsy!

What test confirmed diagnosis!

(Signed) William T Faysmith M. D.

(Address) 801 N. Kenwood Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Bay Shore Cem. July 29 1927

20 UNDERTAKER — ADDRESS

George A. Weber 2205 Bank St.

AUG 23 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24300 × 185 E 24300

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 4 30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Allan Hogan

(a) RESIDENCE NO. Laurel, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Hogan

6 DATE OF BIRTH (month, day, and year): Oct 1862

7 AGE — Years: 64 — Months: 9 — Days: — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Virginia

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town): Virginia

(State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): unknown

14 Informant: University Hospital

(Address): Lombard & Greene Sts.

15 Filed JUL 29 1927 19

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 26, 19 27, to July 29, 19 27, that I last saw h in alive on July 29, 19 27, and that death occurred, on the date stated above, at 3:10 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation with auricular fibrillation, Shock.

Hypertension & nephritis. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture neck of femur due to patient falling (accidental) prior to the ground. (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Laurel, Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) B. P. Starkey, M. D.

, 19 (Address) Laurel Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Hill Cem Laurel Md — Date of Burial: July 31 1927

20 UNDERTAKER: Edward Fisher — ADDRESS: Laurel Md

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

George E. Woods.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24301 E 24301

CERTIFICATE OF DEATH.

124

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST., 946 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Woods

(a) RESIDENCE NO. 2145 Taylor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Emma V. Woods

6 DATE OF BIRTH (month, day, and year) 11/15/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ~~hrs.~~ or ~~min.~~
	78	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Misc.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Dukehart

(Address) 1817 E. Federal St.

15 Filed 2 [illegible] 1927, 19 C. HAMPTON JONES, M. D. Per RK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28/ 1927

17

I HEREBY CERTIFY, That I attended deceased from 7/7/ 1927, to 7/28/ 1927,

that I last saw h[illegible] alive on 7/28/27, 19,

and that death occurred, on the date stated above, at 3:45 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis with complication

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) arteriosclerosis, nephritis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard Friedman, M. D.

7/28, 1927 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL 8/1/27 19

20 UNDERTAKER Geo. J. Ruth DWG ADDRESS 1731 Hanford Av

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24302

CERTIFICATE OF DEATH.

117

E 24302

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Cathedral & Fayette ST. 19-28 WARD)

2-FULL NAME Paul E. Holdcraft, Jr.

(a) RESIDENCE NO. 1809 W Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Est. 4-1914

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER Paul E. Holdcraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lola G. McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Paul E. Holdcraft Sr.

(Address) 1809 W. Lombard St.

15 Filed 19 Registrar

JUL 29 1927 C. HAMILTON JONES, M. D. Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1927, to July 28, 1927.

That I last saw him alive on July 28, 1927,

and that death occurred, on the date stated above, at 8:40 A m.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis following upon a perforated Acute Appendicitis.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 7-27-27

Was there an autopsy? no.

What test confirmed diagnosis? Operation.

(Signed) W Wallace Walker M. D.

, 19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md. DATE OF BURIAL July 30 1927

20 UNDERTAKER George L. Schwab ADDRESS Frederick

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24303 × 129 E 24303

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 N Stricker St. St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hansford Bayton

(a) RESIDENCE NO. 903 N. Stricker St. St. Ward Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Bayton

6 DATE OF BIRTH (month, day, and year) Oct 10 18 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
65	65	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail Carrier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. Government

9 BIRTHPLACE (city or town) Tapahanna

(State or country) Virginia

PARENTS

10 NAME OF FATHER Author Bayton

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Daughter (Julia Bayton) (Address) 903 N. Stricker St

15 Filed 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27- 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-17 1927, to 7-27 1927, that I last saw him alive on 7-27 1927, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Uraemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Dr. W. T. Saunders M. D.

7-29. 1927 (Address) 1024 N. Stricker St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tappahannock Virginia — Date of Burial July 29 1927

20 UNDERTAKER Kim'l. Chase & Son — ADDRESS 1405 Madison

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

E 24304 — REGISTERED NO. E 24304

1-PLACE OF DEATH

City of BALTIMORE: (No. 514 Norris St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Damon Wilson

(a) RESIDENCE NO. 514 Norris St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Walter Wilson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Ann Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Helen Carter

(Address) 514 Norris St

15 Filed ....., 19.....

C. HAMPSON JONES, M. D.
Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/1927

17 I HEREBY CERTIFY, That I attended deceased from 5/1/1927, to 7/26/1927, that I last saw her alive on 11/24/1927, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) ..... yrs. 2 mos. 26 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) ( ) Carlson, M. D.

1/27/1927 (Address) 20 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. Date of Burial July 28, 27

20 UNDERTAKER: Daniel Easton ADDRESS 916 E. Baltimore

JUL 29 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24305

CERTIFICATE OF DEATH.

129

E 24305

1-PLACE OF DEATH

City of BALTIMORE: (No.) 550 Hanover St., 17 24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Fowler Jones

(a) RESIDENCE NO. 550 Hanover St. 17 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Jones

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
51	49	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Va

PARENTS

10 NAME OF FATHER: Geo Easley

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country):

14 Informant: Bessie Jones

(Address): 550 Hanover St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to July 26, 1927

that I last saw h.. alive on July 26, 1927

and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 1 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) [illegible], M. D.

7-27-1927 (Address) 1126 Druid Hill

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial July 28/1927

20 UNDERTAKER: Daniel Easton ADDRESS 916 E 44

Spec.-7-17-26—A Co.—200 Bks.

24306

HEALTH DEPARTMENT—CITY OF BALTIMORE

384 E 24306

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. 1725 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Howard

(a) RESIDENCE NO. ~~2014~~ 2014 Rose St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colord	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
		1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Frederick Howard

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N C

12 MAIDEN NAME OF MOTHER Lillian Copeland

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Frederick Howard.

(Address) 2014 Rose St

15 Filed JUL 29 1927 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927

17 I HEREBY CERTIFY, That I attended deceased from July 26 1927 to July 28 1927

that I last saw him alive on July 28 1927

and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows: Diarrhea & Malnutrition

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Probably Lues ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted ?

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Lewis M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial July 29 1927

20 UNDERTAKER Dennis Eccles ADDRESS 916 Pine

Very important. See instructions on back of certificate.

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24307

CERTIFICATE OF DEATH.

129E 24307

1-PLACE OF DEATH St Joseph's Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 27-43 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Martha Wade

(a) RESIDENCE NO. 612 W. Glenmore ST. Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 6, 1870

7 AGE: Years 56 Months 10 Days 21 If LESS than 1 day, hrs. or min.

57

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sewing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Wade

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Finn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Owen Wade

(Address): 2266 Riverside Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/27 1927

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1927, to July 27, 1927.

that I last saw her alive on July 27, 1927

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) Many mos ds.

CONTRIBUTORY (Secondary): Cerebral Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) L H Bonanno M. D.

, 19 (Address) 21 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: July 30 1927

20 UNDERTAKER: F. A. Kelbaugh & Son — ADDRESS: 703 Hanover

Spec.—1-10-21—M&T—1500 Bks.

E 24308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 24308

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2714 E Madison St. 7-12 WARD)

2-FULL NAME Susan E Boerner

(a) RESIDENCE No. 2714 E Madison ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Herman C Boerner

6 DATE OF BIRTH (month, day, and year) October 2, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William B. Parkes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Mackenight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Herman Boerner
(Address) 2714 E. Madison Str.

15 Filed JUL 29 1927, 19 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927, to July, 1927, that I last saw h live on July 28, 1927, and that death occurred, on the date stated above, at 620 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) One yrs. 7 mos X ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Ham Williams, M. D.

, 19 (Address) 901 Cumberland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 30 1927

20 UNDERTAKER Josiah Lyser — ADDRESS 1600 W. North Ave

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 24309
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

24-001

E 24309
REGISTERED NO.

CITY OF BALTIMORE: (No.) 189 Washington ST. Boulevard WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Parker

(a) RESIDENCE NO. 189 Washington ST. Blvd WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Alfred L. Parker

6 DATE OF BIRTH (month, day and year) Aug 3, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .. min.
	69	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Friesh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hohenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Melin
(Address) 189 Washington Blvd

15 Filed JUL 29 1927 19 HARRISON JONES, M.D. Registrar
Per RMH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 2nd, 1926, to July 27th 1927.

that I last saw her alive on July 27th, 1927.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Sclerosis.

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard E. Bostrom, M. D.

7/29/1927 (Address) 5306 E. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Aug 2 1927

20 UNDERTAKER Joseph Syfer — ADDRESS 1600 W North Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24310

CERTIFICATE OF DEATH.

15-67 188-003

E 24310

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 15-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robin Milburn Widerman

(a) RESIDENCE NO. 2943 W. North Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Widerman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew N. Widerman

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Dietzel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mr. Andrew N. Widerman

(Address) 1817 Whitmore Avenue

15 Filed 7/29 19 27 C. P. RAMSBURG JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 1 ds.

July 29/27 (Signed) G. A. Stader M. D.

(Coroner)

(Address) 149 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Date of Burial 7/30/27

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Baltimore St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24311

CERTIFICATE OF DEATH.

12/9 E 24311

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 808 N Bruce St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Hopkins

(a) Residence No. 808 N. Bruce St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND ~~(or wife) of~~ WIFE of Myrtina Hopkins

6-DATE OF BIRTH (month, day and year) Sept 27-1887

7-AGE. 39 yrs. 10 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Cement work

(c) Name of employer. Mr. Philip Lemon

9-BIRTHPLACE (city or town) Laurel Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Nathaniel Hopkins

11-BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country),

14- (Informant) Mertina Hopkins

(Address) 808 N. Bruce St

15- Filed JUL 29 1927 19.. C. HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 28/27

17- I HEREBY CERTIFY, That I attended deceased from July 7 19 27 to July 28 19 27

that I last saw h.. alive on July 27 19 27

and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ✓ yrs. 1 mos. ✓ ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(Duration) 1 yrs. ✓ mos. ✓ ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. L. Brannon M. D.

7/28, 19 27 (Address) 700 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn

DATE OF BURIAL. July 29 19 27

20-UNDERTAKER. Lewis Easton

ADDRESS 916 Eutaw

Spec.—1-12-23—M&T—500 Bks.

E 24312

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 25-001

E 24312

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3638 Church ave ST. Whittemore Park WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda A Fears

(a) RESIDENCE No. 3638 Church ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Fears

6 DATE OF BIRTH (month, day, and year) Jan 15 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Del

PARENTS

10 NAME OF FATHER Solomon Vandergraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Mt Kinney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mt Kinney

14 Informant Stephen Paul

(Address) 3638 Church ave

15 Filed JUL 29 1927 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1927, to July 29, 1927, that I last saw her alive on July 27, 1927 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. 4 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) P. G. Dill M. D.

7/29, 1927 (Address) 1509 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Christ Church Cemetery Middleburg Co Va

DATE OF BURIAL July 31 1927

20 UNDERTAKER W M Routzon

ADDRESS 2238 N Gay St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24313

CERTIFICATE OF DEATH.

78 E 24313

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. No-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J. Dudley

(a) RESIDENCE NO. 3217 McElderry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Millsback

6 DATE OF BIRTH (month, day, and year) June 1, 1890

7 AGE	Years	Months	Days 27	IF LESS than 1 day.....hrs. or.....min.
	37	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Not employed at time of death

9 BIRTHPLACE (city or town)

(State or country) Detroit, Mich.

PARENTS

10 NAME OF FATHER Thomas E. Dudley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Detroit, Mich

12 MAIDEN NAME OF MOTHER Margarette Law

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Canada

14 Informant Mrs. Lillian Dudley

(Address) 3217 McElderry St.

15 Filed ..... 19 .....

C. HARRISON JONES, M. D.

per ..... Registrar

Via Penn. R.R. - Escort - Mrs. Lillian Dudley

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Edema of lungs

(duration) ..... yrs. ..... mos. ..... ds.

July 29 1927 (Signed) G. C. Jones M. D.

(Coroner)

(Address) 143 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Detroit, Michigan Date of Burial July 29 1927

20 UNDERTAKER Henry H. Mears & Son ADDRESS 805 N. Calvert St.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24314

E 24314

CERTIFICATE OF DEATH.

REGISTERED NO. 24-35

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1436 E Fort Ave Ward 24) WARD)

2-FULL NAME Mary Caughlan

(a) RESIDENCE NO. 1436 E Fort Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs — mos — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of John Caughlan

6 DATE OF BIRTH (month, day, and year) July 22. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	69	x	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Frank Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr John Caughlan (Address) 1436 E Fort Ave

15 Filed JUL 29 1927 19 RMK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to July 25, 1927, that I last saw her alive on July 24, 1927, and that death occurred, on the date stated above, at 12½ a m

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal + Rectal Neoplasm (duration) yrs. mos. 7 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) Kenneth B Boyd, M. D.

, 19 (Address) Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, C. P. Co.

DATE OF BURIAL July 30 1927

20 UNDERTAKER Chas. L. Sherwood

ADDRESS 1511 E Fort

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24315

129 E 24315

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. Monument & Fulton St. 13-54 Ward)

2-FULL NAME Jennie Siegel

(a) RESIDENCE NO. 1226 W North Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Raphael Siegel

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 37 | Months — | Days — | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Russia

PARENTS

10 NAME OF FATHER Herman Seleven

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Russia

12 MAIDEN NAME OF MOTHER Little Rock

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Russia

14 Informant Herman Seleven

(Address) 1226 W Fayette St

C. HARRISON JONES, M. D.

15 Filed JUL 25 1927 19____ By R.H.L. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1927. 19

17 I HEREBY CERTIFY, That I attended deceased from 7-21, 19 27, to 7-24, 19 27, that I last saw h.. alive on 7-24, 19 27, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W. Edmund Levin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale Date of Burial: July 27 19 27

20 UNDERTAKER: Jack Levin ADDRESS: 439 Edgar St

Spec.—1-10-21—M&T—1500 Bks.

E 24316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24316

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Clarks Lane ST., 27-63 WARD

2-FULL NAME Frederick Berger

(a) RESIDENCE NO. 6 Clarks Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Marie K Berger

6 DATE OF BIRTH (month, day, and year): March 4, 1860

7 AGE: 67 Years 4 Months 24 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Trucker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: August Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Kirchpfeil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs M. Kate Burger (Address) Clarks Lane

15 Filed July 29 1927 C. HAMPSON JONES, M. D. Registrar Per RMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to July 28, 1927, that I last saw him alive on July 28, 1927, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Gastric Hemorrhage

(duration) Few Hours yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) C. B. Emrich, M. D.

7-29, 1927 (Address) 5106 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem. DATE OF BURIAL: July 29 1927

A UNDERTAKER: Chas. E. Frances ADDRESS: 80 N Madison Av

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24317 ✓ E 24317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. JOseph's Hospital St., 11-24-57 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Powers

(a) RESIDENCE No 226 W. Madison St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer) 69
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Powers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14
Informant J. W. Powers
(Address) 226 W. Madison St.

15
Filed 192
Per Registrar
G. HAMPSON JONES, M. D.
JUL 29 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. ds.

(Signed) J. H. Watts, M. D.
(Coroner.)

7/27/27. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/30/27

20 UNDERTAKER Chas. P. Graul & Son ADDRESS 118 W. Mt. Royal Ave

Spec.—12-9-25—A Co.—200 Bks.

E 24318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 24318

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 725 N Port St. 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Cada

(a) RESIDENCE NO. 725 N Port St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Cada

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Schmidt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bohemia

14 Informant Barbara Poth

(Address) 725 N Port St

15 Filed ..... 19 ..... HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 19.., to July 27, 19 27, that I last saw her alive on July 27, 19 27, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma: Vesicae

(duration) ..... yrs. ..... mos. Over ds.

CONTRIBUTORY .....

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscope

(Signed) Louis Haase, M. D.

, 19 (Address) 700 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial July 30 19 27

20 UNDERTAKER: Frank Conchon — ADDRESS 1906 Eastern Ave

E 24319

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24319

X 90

Registered No. C .....

1 PLACE OF DEATH

City of Baltimore (No 100 E 23d St. 26-44 Ward)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Coordt.

(Residence in Baltimore: No. (2 mos.) 4202 Hanford Terrace St.; yrs. 2 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH Feb. (Month) 10 (Day), 1864 (Year)

7 AGE 63 yrs. 5 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) 31

9 BIRTHPLACE (State or country) Denmark

PARENTS

10 NAME OF FATHER Chris Bendicksen

11 BIRTHPLACE OF FATHER (State or country) Denmark

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (State or country) Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hannah Sands

(Address) 4202 Hanford Terrace

15 C. HAMPSON JONES, M. D.

Filed ..... 1927, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 29 (Day), 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to July 29, 1927, that I saw h[er] alive on July 28, 1927, and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficency
(arteriosclerosis)

(Duration) yrs. mos. 3 ds.

Contributory (SECONDARY) Ulcerative colitis

(Duration) 2 yrs. — mos. — ds.

(Signed) Harvey B Beach M. D.

July 29, 1927 Address 100 E 23d St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Hastings Neb.

19 PLACE OF BURIAL OR REMOVAL Hastings Nebraska

DATE OF BURIAL July 29, 1927

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Pleasant St

Be very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24320 — CERTIFICATE OF DEATH. 86-001 — E 24320

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 E. 25th St. 12-50 WARD)

2-FULL NAME Henry Andrew Abrams

(a) RESIDENCE NO. 1423 E. 25th ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 10-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas H. Abrams Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Agnes V. Seybold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Chas H. Abrams Jr.
(Address) 423 E. 25th St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25th, 1927, to July 28th, 1927, that I last saw him alive on July 28th, 1927 and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis (Simple)

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Otitis

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Wm. J. Hamilton, M. D.

(Address) 1701 N. Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: St Charles Cemetery Pikesville 7-30-27

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS: 1827 W North Ave

IMPORTANT: See instructions on back of Certificate.

JUL 29 1927 C. HAMPSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24321

CERTIFICATE OF DEATH.

1947 E 24321

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 128 N. Milton Ave St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. White

(a) RESIDENCE NO. 128 N. Milton Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olive Lee White

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
about 63				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town)

(State or country) Matthews Co., Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Paul White (son)

(Address) Greensboro, N.C.

15 Filed _____, 19__ C. HAMPTON JONES, M. D. Registrar

1927 — A.C.M.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jul 28/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency (chronic)

_____ (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Heat Prostration

_____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Walker M. D.

(Coroner)

7/29/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Matthews Co. Va. Date of Burial July 29 1927

20 UNDERTAKER Wm. C. Black ADDRESS 2211 N. Broadway

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

20B 9656 21322

139 E 24322

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia Segrains

(a) RESIDENCE NO. 1729 Mc Culloh St. Ward 8th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Segrains

6 DATE OF BIRTH (month, day, and year) July 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio

(State or country)

PARENTS

10 NAME OF FATHER Chris Mc Daniels

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Nancy Mc Daniels

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Friends

(Address)

15 Filed ..... 19.... Registrar

JOHNS HOPKINS HOSPITAL M. D.

C. HAMILTON JONES, M. D.

1927 Per MCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1927

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1927, to July 27, 1927, that I last saw her alive on July 27, 1927 and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Secondary anemia

Unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Anaphylactic shock after transfusion (10 few minutes

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Herbert F. Traut, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

Date of Burial 6/30/1927

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

Very Important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

E 24323

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24323

CERTIFICATE OF DEATH

100-001

1-PLACE OF DEATH Union Memorial Hosp 15-66 REGISTERED NO.

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William Henry Lotz

(a) RESIDENCE NO. 2135 Mt Holly ST. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): ~~Widowed~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura V. Lotz

6 DATE OF BIRTH (month, day, and year): age 77 yrs Oct 22. 1850

7 AGE: Years 76 Months 9 Days 6 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Druggist

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Laura V. Lotz

(Address) 2135 Mt Holly ST

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to July 28, 1927, that I last saw h[illegible] alive on July 27, 1927, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Gangrenous Gall Bladder

Operation - old age & Weakness

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Old age & General Weakness Bronchio pneumonia

(duration) yrs. mos 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of July 25

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) R O Belford, M. D.

7-28 1927 (Address) Union Mem. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn. Date of Burial July 30 1927

20 UNDERTAKER: Mr. & Mrs. John W. Teufel & Son ADDRESS 801 N. Fayette

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24324

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimofe General Hospital Ward) 712

REGISTERED NO. 188-03

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Justine Wahl.

(a) RESIDENCE NO. 806 N.Port St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, ~~widowed, or divorced~~ (or) WIFE of Conrad Wahl.

6 DATE OF BIRTH (month, day, and year) September 18, 1849

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER Andrew Weismiller.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Carrie Meetscher.(daughter)

(Address) 806 N.Port St.

15 Filed..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Femur. Shock.
Struck and knocked down by an automobile while crossing the street. Accidental Death.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) H. C. Pennacchi M. D.
(Coroner)

7/29 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Fort Ave & Haubert St. July 19, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery Date of Burial July 30 1927

20 UNDERTAKER Thos C. Miller & Son ADDRESS 2334 Jefferson

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24325

CERTIFICATE OF DEATH.

188-010

188 E 24325

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital 9-45 St., (Ward)

2-FULL NAME Henry F C Gudemus

(a) RESIDENCE NO. 2199 Kentucky St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21-1911

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	15	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick W. Gudemus

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Cathrin Hoffenbeck

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Cathrin Gudemus

(Address) 2119 Kentucky Ave

15 Filed....., 19..... M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull, (base)

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 1 ds.

Signed (Coroner) M. D.

19 (Address) 143 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

(Where was disease contracted, if not at place of death?)

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial July 30, 27

20 UNDERTAKER Mrs C. Miller & Son ADDRESS 2337 Jefferson St

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24326

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-002

E 24326

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hosp. REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert St. 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Raymond Earle

(a) RESIDENCE NO. 2426 E. Chase St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Earle

11 BIRTHPLACE OF FATHER (City or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Kountz

13 BIRTHPLACE OF MOTHER (City or town) Md.
(State or country)

14 Informant Mother
(Address)

15 Filed ; 19 Registrar

JUL 29 1927 R.F.P.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1927, to July 28, 1927, that I last saw him alive on July 28, 1927, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Severe Diarrhea
Intoxication

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. J. Belford, M. D.

(Address) Un. Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial July 30 1927

20 UNDERTAKER Thos. C. Miller & Son — ADDRESS 2334 Jeff. St.

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

90 5B 324327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ E 24327

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alva Ayers

(a) RESIDENCE NO. 607 E Francis-St St. Ward Tampa - Fla -

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Clarence Ayers

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Graduate Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Florida

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Ill -

(State or country)

12 MAIDEN NAME OF MOTHER Mary Stricker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Friends -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... C. HANSON JONES, M. D. Registrar

RMH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1927, to July 29, 1927, that I last saw h.. alive on July 29, 1927, and that death occurred, on the date stated above, at 1 P- m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - Sarcoma (Malignant)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 7/29/27

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Study

(Signed) George Dock, M. D.

7/29/1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tampa Florida — Date of Burial July 29 1927

20 UNDERTAKER John O. Mitchell — ADDRESS 1900 Eutaw place.

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24328

CERTIFICATE OF DEATH.

74-081

E 24328

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1531 Jefferson St. 6-9 Ward)

2-FULL NAME Laura Jane Jones

(a) RESIDENCE NO. 1531 Jefferson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX —

4 Color or Race — 5 Single, Married, Widowed, or Divorced. (write the word)

Female colored married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles S. Jones

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE — Years 62+ — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER Moses Hicks

11 BIRTHPLACE OF FATHER (city or town) Balto Co.

(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Howard

13 BIRTHPLACE OF MOTHER (city or town) Balto Co.

(State or country) Md

14 Informant Clara Gwynn

(Address) 539 N Bond St.

15 Filed 7-29 1927 Per RRH Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1927

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1927, to July 27, 1927, that I last saw h-- alive on July 27, 19..., and that death occurred, on the date stated above, at 10 50 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

about 30 minutes (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis and Summer Heat

Irregular (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

7-29 1927 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Loreley M. C. — 7-30 1927

20 UNDERTAKER — ADDRESS

Mrs Chas S. Bailey — 1421 Jefferson St

Very Important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24329

CERTIFICATE OF DEATH.

76 ✓ E 24329

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St. 20-27 Ward)

2-FULL NAME Mrs Catherine Lister

(a) RESIDENCE NO. Home for Aged of the M E Church St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Lifetime mos. dy. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. dy.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~White~~ Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Thomas Lister

6 DATE OF BIRTH (month, day, and year): DEC 10 - 1844

7 AGE: Years 82 | Months 7 | Days 18 | IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. Ashley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Watts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant: Miss Etta Cuddy

(Address) 400 N Fulton Ave

15 Filed ..., 19... RHH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 ..., 1927, to July 28 ..., 1927, that I last saw her alive on July 28 ..., 1927, and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

Paresis

(duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 3 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Methods

(Signed) George L. Shannon, M. D.

7/29, 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Date of Burial July 30 1927

20 UNDERTAKER: George J. Smith ADDRESS 1332 Hollins

1927 C. HEMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24330 | CERTIFICATE OF DEATH. | E 24330

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 24-32 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Clarke

(a) RESIDENCE NO. 1228 Hull ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9. 1912

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James Clark

(Address) 1228 Hull St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to July 29, 1927, that I last saw h alive on July 29, 1927, and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows:

Glomerular nephritis

(duration) yrs. mos 22 ds.

CONTRIBUTORY (Secondary) cerebral edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C Friedman, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL aug 1 1927

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

C. HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24331

CERTIFICATE OF DEATH.

91 E 24331

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McCabe

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
73	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER John Ennis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Lafton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St

15 Filed ..... 19..... C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th 1927

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19..., that I last saw her alive on July 26, 1927, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Albanese, M. D.

July 27, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cem. (Govans) Date of Burial July 30 1927

20 UNDERTAKER Margaret G. Flynn ADDRESS 1412 Light St.

Very Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24332

CERTIFICATE OF DEATH.

179 E 24332

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 12-50 St. _____ Ward)

2-FULL NAME George Hall

(a) RESIDENCE NO. 2212 Hunter St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charlotte Hall

6 DATE OF BIRTH (month, day, and year) June 4 1874

7 AGE: Years 3 Months 3 Days 24

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Glover

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant C. Hall

(Address) 2212 Hunter

15 Filed July 29, 1925 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns due to gasoline accidentally received

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

Signed July 29 Chas. Hampson Jones (Coroner) M. D.

, 19 25 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the City or town State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. Date of Burial July 31 1925

20 UNDERTAKER: C. J. Brown & Son ADDRESS 139 W. Pratt

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24333

E 24333

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: No. 1st Ave & 17th St., (or Ward) 26-36

2-FULL NAME Frank J Armheim

(a) RESIDENCE NO. 1st Ave & 17th St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married —

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ida Armheim

6 DATE OF BIRTH (month, day, and year) August 23-1873

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	53	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Waxman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Joseph Armheim

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Berger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Ida Armheim

(Address) 1st ave 17th St

15 Filed ..... 19 ..... Registrar

1927 C. HAMPSON JONES

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest, and from Autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) C L Laushin

(duration) yrs. mos. 1 ds.

July 28/27 (Signed) H C Hadsell M. D.

(Coroner)

143 N Dray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial July 30, 27

20 UNDERTAKER Lilly Zeiler ADDRESS 403 S Wolfe

Carefully supply all information called for. Write DEATH in plain terms, so that it can be understood. See instructions on back of certificate. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 are very important.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24334

CERTIFICATE OF DEATH

57

E 24334

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 607 So Bouldin St. 12th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kunigunda Zorn

(a) RESIDENCE NO. 607 So Bouldin St. 9 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, ~~Married~~, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Karl Zorn

6 DATE OF BIRTH (month, day, and year): July 29 1877

7 AGE: Years 70 Months — Days —

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany.

PARENTS

10 NAME OF FATHER: Karl Zorn

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Max Zorn

(Address): 607 So Bouldin St

15 Filed ....., 19 .....

C. HAMPSON JONES M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19—: July 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1926, to July 28, 1927

that I last saw her alive on July 28, 1927

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows: Uraemia (Chr Bright's + hypertension Generalized arteriosclerosis) — 3 days

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes mellitus (5 yrs

Post Hemiplegia 3/4

(duration) yrs. mos. dys.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phy. exam.

(Signed) Louis F. Simmons, M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Hearts Cemt — Date of Burial: aug 1 1927

20 UNDERTAKER: Lilly Zeiler Co — ADDRESS: 403 So Wolfe

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24335

CERTIFICATE OF DEATH

99-002 E 24335

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 819 S. Decker ave St., V-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbra Goepfert

(a) RESIDENCE NO. 819 S. Decker ave St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of: George Goepfert.

6 DATE OF BIRTH (month, day and year): July 18 1844

7 AGE: Years 83 Months — Days 9

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): (State or country) Germany.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town): (State or country) Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Germany.

14 Informant: Bernding Edert.

(Address) 819 S. Decker ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to July 25, 1927, that I last saw h[illegible] alive on July 25, 1927, and that death occurred, on the date stated above, at 1.50 m.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. L. Burke, M. D.

19 (Address) July 28, 1927 3042 Auden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Hearts Cath Aug 1 1927 — Date of Burial

20 UNDERTAKER: Lilly & Zeiler Co — ADDRESS 4031 W. Wolfe

Very Important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Anna P. Murphy. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24336

CERTIFICATE OF DEATH

54 E 24336

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 9-46 Ward)

BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna P. Murphy

(a) RESIDENCE NO. 711 E. 30th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S. if of foreign birth [illegible] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon J. Murphy

6 DATE OF BIRTH (month, day, and year) 4/17/1899

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Edward Vincenti

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Alice Moore

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant

(Address) [redacted]

15 Filed [illegible], 19 [illegible] Registrar

Per RRH

BALTIMORE CITY HOSPITALS

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28/1927.

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to July 28, 1927

that I last saw her alive on July 26, 1927

and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Abdominal, acute.

Abdominal hemitis a

Pyelonephritis. Pellagra

(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY Bronchopneumonia

(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? P

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Path.

(Signed) C. Hampson Jones M. D.

(Address) BALTIMORE CITY HOSPITALS

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St. Patrick's Cem, — 8/1/27 19

20 UNDERTAKER — ADDRESS

Geo. J. Ruth — 1735 Hanford

AUG 1927

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 24337

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-81 E 24337

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2037 Hoffman St. 8-13 Ward)

2-FULL NAME Mary Petry

(a) RESIDENCE NO. 2037 Hoffman St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26. 1937

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Md

PARENTS

10 NAME OF FATHER Alexander Wm Petry

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Mary Rose

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md

14 Informant John M. Petry

(Address) 2037 Hoffman

15 Filed _____ 19 _____ Registrar

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1937

17 I HEREBY CERTIFY, That I attended deceased from 7/28 1927, to 7/28 1927, that I last saw h[illegible] alive on 7/28 1927, and that death occurred, on the date stated above, at 11:25 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Edward Jacobs, M. D.

7/28 1937 (Address) 418 Brookington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Hospital Lecture 7/29 1937

Date of Burial

20 UNDERTAKER

ADDRESS

Very important. See instructions on back of certificate.

JUL 29 1937 C. LAMPSON JONES Registrar

Per Capt

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24338

CERTIFICATE OF DEATH

129 E 24338

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen'l Hospital St., 1934-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mamie Earle

(a) RESIDENCE NO. 1257 Williams St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 2 mos. 26 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Raymond Earle

6 DATE OF BIRTH (month, day, and year): 5-15-1900

7 AGE: Years 27 Months 2 Days 26

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: John Smith

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Clarissa Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Hosp. Records

15 FILED ..... 19..... Registrar

C. HAMPSON JONES, M. D.

Per Rock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 7-28-27

17 I HEREBY CERTIFY, That I attended deceased from 7-14-27, 19..., to 7-28-27, 19...,

that I last saw her alive on 7-26-27, 19...,

and that death occurred, on the date stated above, at 12 15 P.m.

The CAUSE OF DEATH* was as follows: Chr Nephritis - Chr. Myocarditis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia (Ulcers organs (5 days))

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Jamison, M. D.

, 19 (Address) Maryland Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem Aug 1, 19 27

Date of Burial

20 UNDERTAKER: A. Howard Evans ADDRESS 386 E. Fayette

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 24339

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24339

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 1833 S Chas St. 23-32 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs John Baynes

(a) RESIDENCE NO. 1833 S Chas St. 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 28 27

7 AGE: Years | Months | Days | IF LESS than 1 day 9 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: John Baynes

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary McAmbrose

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: John Baynes

(Address): 1833 S Chas St

15 Filed ....., 19 .....

Registrar

P.P.A

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1927

17 I HEREBY CERTIFY, That I attended deceased from July 26 1927 to July 28 1927

that I last saw h.. alive on July 26 1927

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy! No

What test confirmed diagnosis?

(Signed) R. L. Cumpston M. D.

(Address) 164 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. Date of Burial July 30, 1927

20 UNDERTAKER: A. Howard Evans ADDRESS 38 E. Fayette Ave.

Very Important. See Instructions on back of Certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24340

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24340

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hosp. REGISTERED NO. 113 18-24

City of BALTIMORE: (No. 33rd & Calvert St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Annalee Peterson

(a) RESIDENCE NO. 47 S. Schroeder St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. // ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 7/1927

7 AGE: Years Months 6 Days 20

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ~~Wis~~ Md

(State or country)

PARENTS

10 NAME OF FATHER Richard L. Peterson

11 BIRTHPLACE OF FATHER (City or town) Wis.

(State or country)

12 MAIDEN NAME OF MOTHER Violet E Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Violet Peterson

(Address) 47 S. Schroeder St

15 Filed ..... 19 .....

Registrar

C. HARRISON JONES, M. D.

JUL 30 1927

RRR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 7/29/27

17 I HEREBY CERTIFY, That I attended deceased from 7/25, 1927, to 7/29, 1927

that I last saw her alive on 7/29/27, 19

and that death occurred, on the date stated above, at 4:10 A.m.

The CAUSE OF DEATH* was as follows:

Severe diarrhea & intoxication

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Alan Blatson, M. D.

7/29, 1927 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cem Hampstead — Date of Burial: July 30/1927

20 UNDERTAKER: J Walter Davis — ADDRESS: 3367 Pine St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24341

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24341

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 667 George ST. 17-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Pollard

(a) RESIDENCE No. 667 George ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb, 1852

7 AGE: Years 45; Months 5; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Potter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant: Mendora Green

(Address) 667 George St

15 Filed JUL 30 1927 19 [illegible] Deputy

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1927

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to July 27, 1927, that I last saw him alive on July 27, 1927, and that death occurred, on the date stated above, at 10450 m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) V Dem Williams, M. D.

, 19 (Address) 611 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL July 31 19 27

20 UNDERTAKER: Samuel Hensley ADDRESS 578 N Bdle

Spec.—12-9-25—A Co.—200 Bks.

E 24342 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 24342

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 518 N Stockton St., 18-23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Magruder

(a) RESIDENCE NO. 518 N Stockton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): June 27 1862

7 AGE: Years 65 Months 1 Days 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): not Know

(State or country)

PARENTS

10 NAME OF FATHER: not know

11 BIRTHPLACE OF FATHER (city or town)

(State or country): not Know

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): not Know

14 Informant: C Muse

(Address): 518 Stockton

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 19 27

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to July 28, 1927, that I last saw h.. alive on July 28, 1927, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uranalysis

(Signed) [illegible], M. D.

July 30, 1927 (Address) 2005 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Date of Burial July 30 1927

20 UNDERTAKER: Joseph A Lucky ADDRESS 409 N Mount Street

JUL 30 1927 HAMILTON BOOKS M

Very Important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24343

CERTIFICATE OF DEATH

E 24343

1-PLACE OF DEATH

REGISTERED NO. 12-19

City of BALTIMORE: (No. Church Home & Infirmary St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Hoffman Ogle

(a) RESIDENCE NO. 1810 St. Paul Street St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 8 ds. How long in U. S. if of foreign birth 60 yrs. 2 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4. Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May-21-1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	60	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Ogle

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland.

14 Informant Miss. Florence I. J. Ogle. (sister)

(Address) 1810 St. Paul Street. City.

15 Filed ..., 19...

Per ... Registrar

C. CAMPBELL JONES, M. D.

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 15, 19 27 to July 29, 19 27

(that I last saw him alive on July 29, 19 27

and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Multiple Sclerosis

(duration) 12 yrs. (approximately)

CONTRIBUTORY

(Secondary)

Cystitis (duration) ? yrs. mos. ds.

18 Where was disease contracted at home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) George B. Brune, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Aug-1-27 19

20 UNDERTAKER STEWART & MOWEN COMPANY — ADDRESS 106 W. NORTH AVE.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24344 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24344

CERTIFICATE OF DEATH. 161004

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Jackson — ST. 24-34 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Weber. —

(a) RESIDENCE NO. 1628 Jackson ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single (Infant)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 7-29-27

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs or — min.
.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ ans

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country) 1628 Jackson Stret. —

PARENTS

10 NAME OF FATHER William J. Weber —

11 BIRTHPLACE OF FATHER (city or town) Md. —
(State or country)

12 MAIDEN NAME OF MOTHER Marion Creighton

13 BIRTHPLACE OF MOTHER (city or town) Md. —
(State or country)

14 Informant Mother — (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 30 1927 Registrar 1579

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-28- , 1927, to 7-29- , 1927, that I last saw h[illegible] alive on 7-29- , 1927, and that death occurred, on the date stated above, at 1.00 P m.

The CAUSE OF DEATH* was as follows:

Prematurity. —

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Premature Labor. —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Birth wt. + history. —

(Signed) W. Alexander Worley M. D.

, 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 7 30 1927

20 UNDERTAKER Commissioner Health

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24345

E 24345

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 539 Orleans St. 1724 Ward)

2-FULL NAME Doris Mackins

(a) RESIDENCE NO. 529 Orleans St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Richardson

6 DATE OF BIRTH (month, day, and year) about 1831

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	96			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home (Ill)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Julia Ferreira

(Address) 529 Orleans St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Kennedy M. D.

(Coroner)

, 19 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial July 1927

20 UNDERTAKER Hamil Easton ADDRESS 916 Mt

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37-001 E 24346

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Howard

(a) RESIDENCE NO. 205 S. Dallas St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-26-27

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		4 -	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Md - Baltimore City

10 NAME OF FATHER Lee Howard

11 BIRTHPLACE OF FATHER (City or town) Va -

(State or country)

12 MAIDEN NAME OF MOTHER Susie Holland

13 BIRTHPLACE OF MOTHER (city or town) Md -

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1927, to July 29, 1927, that I last saw him alive on July 29, 1927, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Lorraine July 30 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Park Ave

very important. See instructions on back of certificates.

JUL 30 1927 C. BRUCE JONES, M. D.

Spec.–1-10-21–M&T–1500 Blks.

E 24347

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24347

CERTIFICATE OF DEATH.

89

REGISTERED NO. 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 2323 N. Charles ST., WARD

2-FULL NAME Eleanor Eugenia Verney Ditch

(a) RESIDENCE No. 2323 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of W. Scott Ditch

6 DATE OF BIRTH (month, day, and year) Oct 12 1860

7 AGE: Years 66 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER John Verney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hartford Co Md

12 MAIDEN NAME OF MOTHER E Bayly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr W Scott Ditch

(Address) 2323 N. Charles St

15 Filed ..., 19.. Registrar

C. HAMPSON JONES, M. D.

JUL 30 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927

17

I HEREBY CERTIFY, That I attended deceased from January, 1925, to July 27, 1927,

that I last saw her alive on July 27, 1927,

and that death occurred, on the date stated above, at 12.40 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis – Coronary artery disease. Thrombosis of Coronary Artery (January 1925) Angina pectoris (duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Increasing myocardial insufficiency (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Frank D. Smith, M. D.

VII/28/1927 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: July 30 1927

20 UNDERTAKER: John C. Mitchell & Sons

ADDRESS: 1900 Eutaw Place

Spec.–7-17-26—A Co.—200 Bks.

E 24348

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24348

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH — REGISTERED NO. 18-29

City of BALTIMORE: (No. 1127 W Baltimore St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Staib

(a) RESIDENCE NO. 1127 W Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Christina W Staib

6 DATE OF BIRTH (month, day, and year): Nov 29 1843

7 AGE — Years: 83 — Months: 8 — Days: — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Germany.

14 Informant: Mrs Edw Staib

(Address) 1127 W Baltimore

15 Filed ..... 19 .....

Per .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1921, to July 29, 1927.

that I last saw him alive on July 28, 1927.

and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Senile arterio sclerosis Myocarditis

(duration) over 6½ yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Test

(Signed) Harry E Staib M. D.

July 29, 1927 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

Date of Burial: July 1927

20 UNDERTAKER: John O Mitchell Sons

ADDRESS: 1300 Eutaw Place

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

2 D-156

D 24349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-001 E 24349

REGISTERED NO.

*1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J. Quail

(a) RESIDENCE NO. 325 W. Chelland St. Bl2a Ward Hazenfurt-Dna

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-11-26

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	1	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Iowa —

(State or country)

PARENTS

10 NAME OF FATHER John Quail

11 BIRTHPLACE OF FATHER (City or town) Wis —

(State or country)

12 MAIDEN NAME OF MOTHER Rhea Ballroan

13 BIRTHPLACE OF MOTHER (city or town) Iowa —

(State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

JUL 30 1927 — Registrar RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1927, to July 29, 1927, that I last saw he alive on July 29, 1927, and that death occurred, on the date stated above, at 11:20 A m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus, congenital

(duration) life yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 7/27/27

Was there an autopsy? yes

What test confirmed diagnosis? Exam. gross & microscopic

(Signed) George E. Yeuing, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Davenport Iowa — Date of Burial July 30 1927

20 UNDERTAKER John O. Mitchell & Sons — ADDRESS Place

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24350

CERTIFICATE OF DEATH

47

E 24350

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 14 Palmero St., 20-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmira V. Stutts

(a) RESIDENCE NO. 14 Palmero St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 6 mos. 8 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hon. H. Stutts

6 DATE OF BIRTH (month, day, and year): July 20/1848

7 AGE — Years: 74 Months: 0 Days: 8 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore City

(State or country): Md.

PARENTS

10 NAME OF FATHER: Samuel Hynes

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Mrs. George Green

(Address) 14 Palmero ave

15 Filed ....., 19..... Registrar

JUL 30 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 1 1927, to July 28 1927

that I last saw h 4 alive on July 28 1927

and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of L. Breast Endocarditis

(Antecedent)

(duration) 1 yr. Unknown da.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert C. Stutts M. D.

7/29/27 19 (Address) 2157 Belleview Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Aug 1 1927

20 UNDERTAKER: Horace F. Burgess 3631 — ADDRESS: Fulton Ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24351

CERTIFICATE OF DEATH.

E 24351

REGISTERED NO. 49

1-PLACE OF DEATH

City of BALTIMORE: (No. 2654 Oswego Ave. St., 15-58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leopold Stern.

(a) RESIDENCE NO. 2654 Oswego Ave, St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? about 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Stern.

6 DATE OF BIRTH (month, day, and year) Aug 11/1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Local Representative

(b) General nature of industry, business, or establishment in which employed (or employer) Mfg Dresses

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Myron Stern.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Samuel J. Fisher.

(Address) 704 Union Trust Bldg.

15 Filed ....., 19..... C. CLAYTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15 1927, to July 29 1927, that I last saw him alive on July 26 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Bladder

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Benj. S. Abrahams, M. D.

, 19 (Address) Professional Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem Date of Burial 7/31 1927

20 UNDERTAKER J Ahrens Co ADDRESS 2432 Reisterstown Rd.

Very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

E 24352

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24352

CERTIFICATE OF DEATH

38

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) Baltimore City Hospitals (T.B.) St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Carter

(a) RESIDENCE NO. 522 St. Paul st. St. 11-7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
Unknown 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 0/0

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Moses Carter

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... C. Harrison Jones, M. D.

Registrar

JUL 30 1927

Per MKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
July 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 27, to July 26, 27,

that I last saw him alive on July 26, 27,

and that death occurred, on the date stated above, at 6.20 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis, A.C.N.S.
Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) L.E. Madden, M. D.

7-26-19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Asbury cemetery July 30 1927

20 UNDERTAKER — ADDRESS

Milton Davis 316 N Eden st

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 24353 — CERTIFICATE OF DEATH. 66 — E 24353

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 113 E. Lafayette St., 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert F. Darsey

(a) RESIDENCE NO. 113 E. Lafayette St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Industrial Alcohol Plant
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Francis Darsey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carr

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. Darsey
(Address) 113 E. Lafayette

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Failure
Alcoholism
Found Dead

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

July 29 (Signed) W. C. Riley (Coroner), ____ M. D.
, 19 27 (Address) 1039 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic Cemetery — Date of Burial 8-1-27.

20 UNDERTAKER Martin Fabian Sons — ADDRESS 182 W. Mulberry

Very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

24954

E 24354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 24354

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (T.B.) St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Dorrill

(a) RESIDENCE NO. 702 Pacific st. St. 13-51 Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Dorrill

6 DATE OF BIRTH (month, day, and year) 1888 Aug 14th

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.,
	39	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer 0

9 BIRTHPLACE (city or town) .....

(State or country) South Carolina

PARENTS

10 NAME OF FATHER William Dorrill

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) South Carolina

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

JUL 31 1927 C. HAMPSON, M. D.

By ..... Registrar

RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from March 16 27, 19..., to July 29 27, 19...,

that I last saw him alive on July 29 27, 19...,

and that death occurred, on the date stated above, at 12.25 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. E. Medders M. D.

7-29-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

Date of Burial July 30 1927

20 UNDERTAKER J. A. Cook

ADDRESS 502 E North Ave

very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24355

CERTIFICATE OF DEATH.

90

E 24355

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3427 ODonell St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Kazmiez Kabara

(Residence in Baltimore: No. 3427 ODonell St; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

6-DATE OF BIRTH: unknown. 1.....
(Month) (Day) (Year)

7-AGE: 54 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country): Poland

PARENTS.

10-NAME OF FATHER: Joseph Kabara

11-BIRTHPLACE OF FATHER, (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER, (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joe. Kabara

(Address) 3427 ODonell St

15-

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 29 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Endocarditis (Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

July 30 27 (Signed) C. C. Wades M. D.
(Coroner)

192.. (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

St Stans House Cem Aug 1 1927

20-UNDERTAKER. ADDRESS.

Stephen F Fiakowski 1031 Fremont

REGISTERED JUL 31 1927 G. HAMPTON JONES, M.D.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24356

CERTIFICATE OF DEATH

31 E 24356

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1253 S. Decker Ave St., 1st Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignasius Semenski

(a) RESIDENCE NO. 1253 S Decker St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: 30 Years, Months, Days. IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer

(b) General nature of industry, business, or establishment in which employed (or employer): 034

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore MD

(State or country)

PARENTS

10 NAME OF FATHER John Semynske

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Wisniewska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Agnes Semenska

(Address) 1253 S Decker Ave

15 Filed JUL 31 1927 16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 July 29-27

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1927, to July 29, 1927, that I last saw him alive on July 27, 1927, and that death occurred, on the data stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Five yrs. mos. ds.

CONTRIBUTORY (Secondary) Controlled Cold

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted at home

if not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jos. A. Rosenstock, M. D.

7/30, 1927 (Address) 3118 O'Donnell St. Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem — Date of Burial: Aug 1 — 1927

20 UNDERTAKER: Stephen J Fialkowski — ADDRESS: 1550 Hanover St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24357

CERTIFICATE OF DEATH.

90 E 24357
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5205 Linden Heights Ave St., 27 Ward) 55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura F. Garner

(a) RESIDENCE NO. 5205 Linden Heights Ave St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. / How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wht	Widow

5a If ~~married, widowed, or divorced~~ (or) WIFE of Jas W. Garner

6 DATE OF BIRTH (month, day, and year) July 28 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	—	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Leonard P. Mayo
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md
12 MAIDEN NAME OF MOTHER Ellen Mayo
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Ellen F. Crooks
(Address) 5205 Linden Heights Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to July 29, 1927, that I last saw her alive on July 29, 1927, and that death occurred, on the date stated above, at 11:10 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 6½ ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) E. Miles Wheeler, M. D.
July 30 1927 (Address) 212 W. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. Date of Burial Aug 1 1927

20 UNDERTAKER Harry W. Ellen ADDRESS 1944 W. Northern

Very Important. See instructions on back of certificate.

C. HAMPSON LEWIS, M. D.
JUL 31 1927

Spec.–7-17-26—A Co.—200 Bks.

1927
42

HEALTH DEPARTMENT—CITY OF BALTIMORE

204 E 24358 — CERTIFICATE OF DEATH — 46 E 24358 / 885

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Carter

(a) RESIDENCE NO. 1409 Madison Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	C	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	41	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) [illegible]

12 MAIDEN NAME OF MOTHER Anna Rose

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 31 1927, 19 . Registrar RPK

WAMPLER JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24th 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 18, 19 27, to July 24, 19 27,

that I last saw h alive on July 24, 19 27,

and that death occurred, on the date stated above, at 9¼ m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Extension & occlusion of Ureters and Uremia.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. da.

18 Where was disease contracted ?

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Herbert F. Traut M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial Aug 1 1927

20 UNDERTAKER Laura Bernard Albright — ADDRESS 1617 Mc Cu

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24359

CERTIFICATE OF DEATH.

167-001

REGISTERED NO. E 24359

1-PLACE OF DEATH

City of BALTIMORE: (No. 1524 McHenry St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina C. Reed

(a) RESIDENCE NO. 1524 McHenry St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis F. Reed

6 DATE OF BIRTH (month, day, and year) Aug 28 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto.

PARENTS

10 NAME OF FATHER Wm Rickline

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. Y.

12 MAIDEN NAME OF MOTHER Annie Burr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Louis F. Reed

(Address) 1524 McHenry St.

15 Filed JUL 31 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 28th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest / Inquiry, thereon and from the evidence obtained by said Inquest, and find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Inhaling Illuminating Gas

(duration) Dead when found yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Jno. B. Horton M. D.

(Coroner)

July 29th 1927 (Address) Curtis Bay, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. Date of Burial Aug 1st 1927

20 UNDERTAKER A. Jones ADDRESS 111 S. Gilmor

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24360

CERTIFICATE OF DEATH.

128 E 24360

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2605 Alma St., 7-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Wm Frankenberg

(a) RESIDENCE NO. 2605 Alma St. 7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, ~~Widowed, or Divorced~~, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Mary B. Frankenberg

6 DATE OF BIRTH (month, day, and year) June 26 1888

7 AGE: Years 39 | Months 6 | Days 2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER Jno. H. Frankenberg

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Dunnick

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Mary B Frankenberg

(Address) 2605 Alma

15 Filed....., 19..... Registrar

C. HAMILTON JONES, M. D.

DEC 31 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 4 1927, to July 28 1927, that I last saw him alive on July 28 1927, and that death occurred, on the date stated above, at 9:42 P. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia & Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Cook, M. D.

(Address) 413 Washington

over

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial: Aug 1st 1927

20 UNDERTAKER: Lilly & Zeller

ADDRESS 403 S. Arlington Ave

Very Important. See Instructions on Back of Certificate.

Spec.—1-10-21—M&T—1500 Bks.

Lena Goedeke

E 24361 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

E 24361

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1502 E Oliver ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Goedeke

(a) RESIDENCE NO. 1502 E Oliver ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND (or) WIFE of John Goedeke

6 DATE OF BIRTH (month, day, and year) Mar 23 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick Harling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Runne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Goedeke (Address) 1502 E Oliver St

15 Filed JUL 31 1927 C. HAMPSON JONES, M. D. Registrar

per ARC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1925, to July 28, 1927, that I last saw h[illegible] alive on July 28, 1927, and that death occurred, on the date stated above, at 1130 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J. L. Bumbock M. D.

7-29, 1927 (Address) 1531 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Aug 1 1927

20 UNDERTAKER George Schilling & Sons ADDRESS 1126 E Monument St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24362

CERTIFICATE OF DEATH

202 E 24362

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp. St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter E. Oliver

(a) RESIDENCE NO. 2431 - E. Eager St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 11 mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 12, 1909

7 AGE — Years: 17 — Months: 11 — Days: 16

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Apprentice

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer

9 BIRTHPLACE (city or town): ?

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Walter Oliver

11 BIRTHPLACE OF FATHER (City or town): ?

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Ada Brigerman

13 BIRTHPLACE OF MOTHER (city or town): ?

(State or country): Md.

14 Informant: Mother

(Address) 2431 - E. Eager St.

15 Filed ..... 19 .....

JUL 31 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1927, to July 25, 1927, that I last saw h/m alive on July 24, 1927, and that death occurred, on the data stated above, at 2:16 A m.

The CAUSE OF DEATH* was as follows:

Complication CNS. following Tuberculosis of Tracheal & Bronchial

(duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (Secondary) A. Coroner case

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray & Autopsy

(Signed) Palmer F. C. Williams, M. D.

7/28, 1927 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: Aug 1 1927

20 UNDERTAKER: W. G. Schaeffer — ADDRESS: 1816 Monument

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24363
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

89

E 24363
REGISTERED NO.

CITY OF BALTIMORE: (No. 1802 Thomas ave WARD) 15-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Aro

(a) RESIDENCE NO. 1802 Thomas ave WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Matilda Aro

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
above	76	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

057

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Mrs. Mary Virginia Aro
(Address) 1802 Thomas ave.

15 Filed , 19 . R H K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1927, to July 26, 1927.

that I last saw him alive on July 26, 1927

and that death occurred, on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + hypertension (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence.

(Signed) Geo. B. Lybert, M. D.

, 19 (Address) 1807 Hanford ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Aug 2-1927

20 UNDERTAKER: Weimann Co[illegible] — ADDRESS: 541 E North Ave

THIS IS VERY important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24364

90 E 24364

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] Ward) 4-26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Zuidema

(a) RESIDENCE NO. 107 N. Desmond Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5-9 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1869

7 AGE — Years: 58 — Months: 5 — Days: 9

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.

(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Zuidema

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany ?

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant BALTIMORE CITY HOSPITALS

(Address) Re Cuddy [redacted]

15 Filed ....., 19 .....

JUL 31 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/29/1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to July 29, 1927

that I last saw h[illegible] alive on July 29, 1927

and that death occurred, on the date stated above, at 10.15 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Chronic, acute

Arteriosclerosis.

Convulsions

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Spec

(Signed) C. [illegible] Lynch, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Aug 1 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24365

CERTIFICATE OF DEATH.

129

E 24365

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 28 N. Lakewood ST. 6-10 WARD)

2-FULL NAME Valentine C. Burkhauser

(a) RESIDENCE No. 28 N. Lakewood ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary A.

6 DATE OF BIRTH (month, day, and year) July 15 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	82		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ludwig Burkhauser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Stine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary M. Holshead

(Address) 28 N. Lakewood

15 Filed JUL 31 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927

17

I HEREBY CERTIFY, That I attended deceased from July, 19..., to July 29, 19 27, that I last saw h... alive on July 29, 19 27, and that death occurred, on the date stated above, at 3:4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Hepatic Cirrhosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. H. Weyl Jr., M. D.

..., 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL July 1927

20 UNDERTAKER W. M. Cook

ADDRESS 502 E. North

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24366

CERTIFICATE OF DEATH.

90

E 24366

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1315 W. Saratoga St. 18-21 Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lenox Vincent Cockrell

(a) RESIDENCE NO. 1315 W. Saratoga ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rhoda Cockrell

6 DATE OF BIRTH (month, day, and year) Nov. 3, 1885

7 AGE	Years	Months	Days 26	If LESS than 1 day, hrs. or min.
	41	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) W. Va.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Cockrell

11 BIRTHPLACE OF FATHER (city or town) W. Va.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Avis

13 BIRTHPLACE OF MOTHER (city or town) W. Va.
(State or country)

14 Informant Mrs. Rhoda Cockrell
(Address) 1315 W. Saratoga St.

15 Filed JUL 31 1927 19 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th 1927

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to July 29, 1927, that I last saw him alive on July 29, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonitis
Carcinomatosis
Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. Glasscock, M. D.

July 30 19 27 (Address) 1510 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlestown W. Va.	Aug 2 1927
20 UNDERTAKER	ADDRESS
Harry E. Wilkes 1530	Lombard St.

Spec.-7-17-26—A Co.—200 Bks.

E 24367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 24367

REGISTERED NO.

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [redacted] St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Brandle

(a) RESIDENCE NO. Woodbourne Ave Ward 26-37

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 44 Months Days IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chair caner.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Brandle

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ? Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ? Germany

14 Intermant BALTIMORE CITY HOSPITALS

(Address) Leonardo

15 Filed ....., 19.....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24/ 1927.

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1927 to July 24, 1927

that I last saw him alive on July 24, 1927

and that death occurred, on the date stated above, at 2.00 A.M.

The CAUSE OF DEATH* was as follows:

C. N. S. Complications

Optic atrophy - Inherited

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage.

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? General & Symptoms

(Signed) C. Holmes George, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer — Aug 1 1927

20 UNDERTAKER George J. Smith — ADDRESS 1532 Hollins

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24368

CERTIFICATE OF DEATH

7H-001

E 24368

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3404 Fairview ave W. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Saunders

(a) RESIDENCE NO. 3404 Fairview Ave W. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 20 1840

7 AGE: Years 87 Months Days 9 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lake George N. Y.

PARENTS

10 NAME OF FATHER: Joseph Saunders

11 BIRTHPLACE OF FATHER (City or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Eliza Crosby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. S.

14 Informant: George E. Saunders

(Address): 3306 Powlatan Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1927, to July 29, 1927,

that I last saw h... alive on July 29, 1927,

and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) A. K. Felsenfeld, M. D.

, 19 (Address) Duvall & Clarkson Bldg. Pa. 4815.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Aug 1 1927

20 UNDERTAKER: George J. Smith — ADDRESS 1532 Hollins

Per RMC

Spec.—1-12-23—M&T—500 Blks.

E 24369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 E 24369

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hospital ST., ... WARD) 12-51

2-FULL NAME Andrew Blair Jr.

(a) RESIDENCE No. 280 - 86th St. Brooklyn, N. Y. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mrs Katherine Blair

6 DATE OF BIRTH (month, day, and year) July 2 - 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	39	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U S Estbeck

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Andrew Blair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Hospital Records (Address)

15 Filed JUL 31 1927, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1927

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1927, to July 30, 1927, that I last saw him alive on July 30, 1927, and that death occurred, on the date stated above, at 6 10 A.M. in

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) yrs. 3 (?) mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical findings & Microscopic tests

(Signed) Otto Boulon, M. D.

7-30, 1927 (Address) Asst Surgeon U. S. P. H. S. U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL July 31 1927

20 UNDERTAKER Geo W Little ADDRESS 2700 Edmondson Ave

Cor.—12-9-25—A Co.—200 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 24370

CERTIFICATE OF DEATH.

182 E 24370

REGISTERED NO.

1-PLACE OF DEATH: Crook Ship yard.

City of BALTIMORE: (No.) Foot of Towson St. St. 24-35 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Helen C. Schlauch.

(a) RESIDENCE NO. 1429 E. Clement St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 2 mos. 5 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ---

6 DATE OF BIRTH (month, day, and year): May 28, 1918.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	9	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of indnstry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Peter Schlauch.

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Hungary.

12 MAIDEN NAME OF MOTHER: Elizabeth Agnes.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Hungary.

14 Informant: Peter Schlauch. (father)

(Address): 1429 E. Clement St.

15 Filed.....19 HAMPSON JONES, M. D. Registrar

BRK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning, while wading in the water.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto Bernhardt M. D. (Coroner)

7/30 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the state .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross 9.9.0. Date of Burial: Aug 1 1927

20 UNDERTAKER: Chas L Stevens ADDRESS: 850 E Fayette

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 24371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 E 24371

1-PLACE OF DEATH Crook Ship yard,

City of BALTIMORE: (No. Foot of Towson St. St., 24-35 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna E. Schlauch.

(a) RESIDENCE NO. 1429 E. Clement St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) January 26, 1920.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	7	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Peter Schlauch.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Hungary.

12 MAIDEN NAME OF MOTHER Elizabeth Agnes.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Hungary

14 Informant Peter Schlauch. (father)

(Address) 1429 E. Clement St.

15 Filed DEC 31 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning, while wading in the water.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Kimbardt M. D.
(Coroner)

7/30 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, A. P. Cem. Aug 1 1927 Date of Burial

20 UNDERTAKER Chas. A. Sivins ADDRESS 1501 Fort Ave

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24372

CERTIFICATE OF DEATH.

1/3 E 24372

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1406 Reynolds ST., 24-35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A Seaburn

(a) RESIDENCE NO. 1406 Reynolds ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Son

6 DATE OF BIRTH (month, day, and year): April 30, 1856

7 AGE: Years 1 Months 2 Days 29 If LESS than 1 day, hrs. or 1 min.

14 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Richard Seaburn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila, P. A.

12 MAIDEN NAME OF MOTHER: Rose Linehard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Rose Seaburn

(Address) 1406 Reynolds

15 Filed Aug 3, 1927 [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/22, 1927, to 7/29, 1927, that I last saw h[illegible] alive on 7/28, 1927 and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

Acute Enteritis

(duration) yrs 7 mos 8 ds.

CONTRIBUTORY (Secondary): Malaria

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) [illegible], M. D.

19 (Address) Wilkens Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: Aug 1 1927

20 UNDERTAKER: Chas L Stevens

ADDRESS: 1511 Fontaine

TION is very important. See instructions on

Spec.—1-12-23—M&T—500 Blks.

E 24373

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24373

CERTIFICATE OF DEATH.

REGISTERED NO. 22-30 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Hanover ST. WARD)

2-FULL NAME George William Hartlove

(a) RESIDENCE NO. 610 Hanover ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gena. Hartlove

6 DATE OF BIRTH (month, day, and year) Oct. 20 73

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John. Hartlove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Hartlove (Address) 610 Hanover

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29 1927

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to July 29, 1927, that I last saw h alive on July 29, 1927 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. C. Campbell M. D.

(Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 8/1 1927

20 UNDERTAKER J. Few McCully — ADDRESS 130 E. Fort

1927 C. HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

E 24374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24374

90 E 24374

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St.) (6 Ward) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Fleischman

(a) RESIDENCE NO. 107 N Potomac St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): M

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Anna M. Fleischman

6 DATE OF BIRTH (month, day, and year): June 9- 1896

7 AGE — Years: 31 Months: 1 Days: 19. If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer): Bartlett Hayward Bath

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Geo Fleischman

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Eliz Geiss

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Mary M. Fleischman

(Address) 107 N. Potomac

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1927

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to July 28, 1927,

and I last saw h~~im~~ alive on July 28, 1927,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Septicaemia (Streptococcus viridans)

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 25 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Repeated blood cultures

(Signed) J. H. McCracken, M. D.

, 19 (Address) Church Home - Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial 8/1 1927

20 UNDERTAKER: J. Groan ADDRESS 3000 E Baltic

Very important. See instructions on back of certificate.

Spec—12-23-21—E.I.&R.S.—400 lbs.

24375

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24375

CERTIFICATE OF DEATH.

E 24375

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 37 N. Harford Road St., 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sarah A. Whitson

(a) Residence No. 37 N. Harford Rd. St., Hamilton Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., If of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph B. Whitson

6-DATE OF BIRTH (month, day and year) Aug 7th 1845

7-AGE. 81 yrs. 11 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Lincolnshire England

PARENTS.

10-NAME OF FATHER. William Walton

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Lincolnshire England

12-MAIDEN NAME OF MOTHER. Eliza Stokes.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

14- (Informant) Mrs. S. J. Whitson

(Address) 37 Harford Rd. Hamilton

15- Filed ... 1927 ... 192.. Registrar.

C. STANTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 29th 27

17- I HEREBY CERTIFY, That I attended deceased from March 1 1927 to July 29 1927 that I last saw h[illegible] alive on July 28 1927 and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. — mos. — ds

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) 2 yrs. — mos. — ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

July 30 1927 (Address) Hamilton Baltimore Md.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Friendship M. E. Cemetery	Aug 1st 1927
20-UNDERTAKER. Frederick Lassahn & Son	ADDRESS Fulleston

Spec.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24376 PLACE OF DEATH

CERTIFICATE OF DEATH.

145-003 E 24376 REGISTERED NO.

City of BALTIMORE: (No. 317 E Lafayette Ave., 12 Ward) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida May Bosley

(a) RESIDENCE NO. 317 E Lafayette Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred unknown ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Chas. Lee Bosley

6 DATE OF BIRTH (month, day, and year): Aug 18 1880

7 AGE — Years: 46 — Months: 11 — Days: 11 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Hagerstown

(State or country): Md.

PARENTS

10 NAME OF FATHER: Frank Williams

11 BIRTHPLACE OF FATHER (city or town):

(State or country): N. Y. N. Y.

12 MAIDEN NAME OF MOTHER: E Daily

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland.

14 Informant: Mr. Chas Lee Bosley

(Address): 317 E Lafayette Ave

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29-1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1927 to July 29, 1927, that I last saw her alive on July 29, 1927, and that death occurred, on the date stated above, at 3 30 p.m.

The CAUSE OF DEATH* was as follows:

Rupture of Uterus in Child Birth. 2nd term

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage of Uterus.

half hour (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John O'Leary, M. D.

, 19 (Address) 1603 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Greenmount Cem. Aug. 1 1927

20 UNDERTAKER — ADDRESS

Wm. H. Redfield 501 N Eutaw St

Aug 1 1927 HAMILTON JONES, M. D. Registrar

RMK.

very important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Blks.

E 24377 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 24377

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 740 Poplar Grove ST. 16-67 WARD)

2-FULL NAME Edward E. Weal

(a) RESIDENCE NO. 740 Poplar Grove ST. ... WARD ...
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Katie L. Weal

6 DATE OF BIRTH (month, day, and year) Feb 12 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel Weal

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Schultz.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

14 Informant Mrs Katie Weal
(Address) 740 Poplar Grove St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/28 .19 27. to 7/30 .19 27
that I last saw him alive on 7/30 .19 27
and that death occurred, on the date stated above, at 1.40 a. m.
The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) ... yrs. ... mos 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller ..... M. D.

.19 (Address) 2134 W. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Aug 1 19 27

20 UNDERTAKER Bernard A Fink

ADDRESS 734 Poplar Grove

C. HAMPSON JONES, M. D.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24378

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

161-001 E 24378

City of BALTIMORE: (No. 124 N. Mount St., 19-27 Ward) Registered No.

2-FULL NAME Baby Boy Dorsey

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 124 N. Mount St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 7/24/27

7-AGE. ~~Yrs. Mos. Ds.~~ If LESS than 1 day, hrs. or 10 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. William Dorsey.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Annedel Co Md.

12-MAIDEN NAME OF MOTHER. Bertina Hardiman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore, Md.

14-

(Informant)

(Address)

15-Filed AUG 1 - 1927 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/29/27.

17- I HEREBY CERTIFY, That I attended deceased from 7/24/27 19 to 7/29/27 19

that I last saw h alive on / / 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. A. Whitehurst M. D.

, 19 (Address) Emerson Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cremated-Forest Park	7/30, 19 27

20-UNDERTAKER. ADDRESS

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24379

CERTIFICATE OF DEATH.

66

E 24379

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 816 Low St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie McCullum

(a) RESIDENCE NO. 816 Low St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 28 Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Samuel McCullum

(Address) 816 Low St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

30 July (Signed) [illegible] M. D.

, 19 27 (Address) 1039 Bruce (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — Date of Burial July 31 '27

20 UNDERTAKER: John W Henderson — ADDRESS 1502 E Monument

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24380
1-PLACE OF DEATH

REGISTERED NO. E 24380

City of BALTIMORE: (No. Union Memorial Hospital St., 27-23 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida M. Crem

(a) RESIDENCE NO. 729 Colorado Ave. St. Roland Park Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Hugh S. Crem

6 DATE OF BIRTH (month, day, and year) Aug 11, 1857

7 AGE	Years	Months	Days 20
	69	11	30

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) New Haven
(State or country) Connecticut

PARENTS

10 NAME OF FATHER David Foot

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Conn.

12 MAIDEN NAME OF MOTHER Jane Roe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Conn

14 Informant Mrs. Hugh S. Crem
(Address) 729 Colorado Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 15, 19 27, to July 31, 19 27,
that I last saw h[illegible] alive on July 31, 19 27,
and that death occurred, on the date stated above, at 12:20 A. m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease

(duration) yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Stethescope to heart
(Signed) John Urban Wonders, M. D.
, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — Date of Burial Aug 2 1927

20 UNDERTAKER John O. Mitchell — ADDRESS Flora

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24381 E 24381

CERTIFICATE OF DEATH.

129

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2527 Pennsylvania Ave. ST. WARD)

2-FULL NAME George Louis Plitt

(a) RESIDENCE NO. 2527 Pennsylvania Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine V. Plitt

6 DATE OF BIRTH (month, day, and year) August 6 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Maximillian Plitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Krupp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs Katherine V. Plitt

(Address) 2527 Pennsylvania Ave

15 Filed AUG 1 - 1927, 19 HANNAH NES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927

17 I HEREBY CERTIFY That I attended deceased from Dec 29, 1925, to July 29, 1927, that I last saw him alive on July 29, 1927, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH was as follows:

*Chronic Myocarditis

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? N/C

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ophs. Exam + urine & Blood

(Signed) Geo Ross Lee M. D.

Aug 1, 1927 (Address) 1702 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk Cemetery — DATE OF BURIAL Aug 1 1927

20 UNDERTAKER Wm J. Tucker & Sons — ADDRESS Ft Pa Ave

Spec.—7-17-26—A Co.—200 Bks.

E 24382

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24382

CERTIFICATE OF DEATH

117

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 12-19

City of BALTIMORE: (No. Olivia Hoyt St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs ~~Hoyt~~ Strickland

(a) RESIDENCE NO. Guilford Apts St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND (or) WIFE of: Charles Hobart Strickland

6 DATE OF BIRTH (month, day, and year): Sept 22- 1877

7 AGE: Years 48 Months 10 Days 9 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Brooklyn (State or country) N Y

PARENTS

10 NAME OF FATHER: Hoyt

11 BIRTHPLACE OF FATHER (City or town) (State or country) Connecticut

12 MAIDEN NAME OF MOTHER: Fay

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Charles H. Strickland (Address)

15 Filed 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/30/27 19

17 I HEREBY CERTIFY, That I attended deceased from 7/24/27, 19, to 7/30/27, 19, that I last saw h alive on 7/30/27, 19, and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Appendicitis & Peritonitis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/24/27

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) J. S. Winstead, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem Md City Date of Burial Aug 2 19 27

20 UNDERTAKER: W. S. Thurston Son ADDRESS Penn

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24383

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24383

CERTIFICATE OF DEATH

117

REGISTERED NO. 15-61

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blessie Mrs. John Fisher

(a) RESIDENCE NO. 3411 Powhatan St Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: John Fisher

6 DATE OF BIRTH (month, day, and year): June 2, 1882

7 AGE: Years 45 Months 1 Days 29

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): West Va.

(State or country)

PARENTS

10 NAME OF FATHER: Thomas J. Showalter

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Rose Brown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): W. Va.

14 Informant: Husband.

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1927

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1927 to July 31, 1927

that I last saw h er alive on July 31, 1927

and that death occurred, on the date stated above, at 7.05 P.m.

The CAUSE OF DEATH* was as follows:

Appendical abcess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of July 26

Was there an autopsy? no.

What test confirmed diagnosis? Operation

(Signed) R. B. Telford, M. D.

7-31, 1927 (Address) Union Mem Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: Aug 3 1927

20 UNDERTAKER: H. Faulmann Sons

ADDRESS: [illegible]

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24384

CERTIFICATE OF DEATH.

100-001

E 24384

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

City of BALTIMORE: (No. ____ St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter L. Richardson

(a) RESIDENCE NO. 112 N. Washington St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Lucy Richardson

6 DATE OF BIRTH (month, day, and year): July 16- 1857

7 AGE — Years: 70 — Months: — — Days: 14 — IF LESS than 1 day.....hrs. or.....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town): ____

(State or country): Va

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): ____

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): ____

(State or country): Unknown

PARENTS

14 Informant (Address): Baltimore City Hospitals

15 Filed ____ 19 ____ Registrar

JUL 1927 HEALTH DEPT. BALTIMORE MD

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 30. 1927

I HEREBY CERTIFY, That I attended deceased from 7-22-27, 19 ____, to 7-30, 19 27, that I last saw him alive on July 30, 19 27, and that death occurred, on the date stated above, at 11.05 p. m.

The CAUSE OF DEATH was as follows:

Terminal Bronchopneumonia

(duration) ____ yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) Psychosis Multiple Cerebral arteriosclerosis

(duration) unknown yrs. ____ mos. ____ ds.

17 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date ____

Was there an autopsy? No (Clinical findings)

What test confirmed diagnosis? ____

(Signed) Harry J. Corbitt M. D.

7/29/27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — Date of Burial: Aug 2 1927

20 UNDERTAKER: Hughes & Jones Inc — ADDRESS: 424 W Broadway

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24385

CERTIFICATE OF DEATH. X 161-002

REGISTERED E 24385

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St.: 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean Janice Peake

(a) RESIDENCE NO. Algonia W. Va. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): June 28, 1927

7 AGE: Years | Months 1 | Days 2 | 30 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Church Home & Infirmary

(State or country)

PARENTS

10 NAME OF FATHER: Jas. Peake

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER: Mary V. Conley

13 BIRTHPLACE OF MOTHER (city or town): Lord Delaware (State or country) Virginia

14 Informant: Jean Peake

(Address) R.F.D. Sons.

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-30 1927.

17

I HEREBY CERTIFY, That I attended deceased from June 28, 1927, to July 30, 1927, that I last saw h[illegible] alive on July 30, 1927, and that death occurred, on the date stated above, at 9 0 m.

The CAUSE OF DEATH* was as follows:

Septicemia — following local lesion on head

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Grainger Gottsdeg, M. D.

. 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery Date of Burial Aug 1 1927

20 UNDERTAKER: Hughes & Jones Inc ADDRESS 1111 W Broadway

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

56 E 24386

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 S Caroline St. 3-4 WARD)

2-FULL NAME Calvin Trusty

(a) RESIDENCE NO. 309 S Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 5 1926

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

11 24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Clifton Yeakins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Rosa Lee Trusty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Rosa Lee Trusty

(Address) 309 S Caroline St

15 Filed 7-30, 19 27 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1927 to July 29, 1927, that I last saw h alive on July 29, 1927, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

July 29, 1927 (Address) 508 Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 8/1 1927

20 UNDERTAKER Byron Wright

ADDRESS 218 McCulloh St

TION IS very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Hacd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24387

REGISTERED NO. E 24387.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St., 26 Ward) 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Heard.

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker.

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed ..... 19 .....

AUG 1 - 1927 Registrar

Per RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927, to July 31, 1927

that I last saw him alive on July 31, 1927

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chr. & acute.

Bronchopneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross + Sub

(Signed) C. Douglas Bond, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Date of Burial 8/1 1927

20 UNDERTAKER Will Cook ADDRESS 5016 Auth

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24388

CERTIFICATE OF DEATH.

188-103

REGISTERED NO. E 24388

1-PLACE OF DEATH

City of BALTIMORE: (No. 140 Mercy Hosp St. 5-8 Ward)

(If death occurred in a hospital or Institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Brown

(a) RESIDENCE NO. 1104 S. Lemington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ruthie Brown

6 DATE OF BIRTH (month, day, and year): Unknown 1873

7 AGE: Years 5 Months 4 Days IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: R. Thomas

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: E. James

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Bessie Chapman

(Address) 1104 Lemington

Filed JUL 1 - 1927 Reg. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the date stated above.

The CAUSE OF DEATH* was as follows:

Prob. Fract. Skull

Fract. Clavicle

and 8 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

2 days (duration) yrs. mos. ds.

July 30 (Signed) W. J. Finlay M. D.

, 19 27 (Address) 1439 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 8 days yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery Date of Burial July 31 1927

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS 1715 Eastland Ave

...very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24389

CERTIFICATE OF DEATH.

117

E 24389

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 915 Rutland ave Ward 7-13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Blake

(a) RESIDENCE NO. 915 Rutland ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Blake

6 DATE OF BIRTH (month, day, and year): unknown 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): ~~unk~~ Va.

(State or country)

PARENTS

10 NAME OF FATHER: George Johnson

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Sarah Morgan

(Address): 915 Rutland ave

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 29. 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 1927, to July 29, 1927, that I last saw her alive on July 29, 1927, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

1. Ureteral Stricture Rt
2. Hydronephrosis Rt
3. Chronic appendicitis Apr 13 to July 29/27 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Apr 13 to July 29/27 (duration) yrs. mos. ds.

18 Where was disease contracted at home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Thorough Examination

(Signed) Sydney Wallenstein, M. D.

, 19 (Address) 2042 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery Date of Burial: Aug 2, 1927

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS: 1725 Ashland ave

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24390

CERTIFICATE OF DEATH.

E 24390

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. 1 St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Carbon

(a) RESIDENCE NO. 212 Aiken St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): 12/20 1913

7 AGE: Years 13 Months 7 Days 9 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: Louis Carbon

11 BIRTHPLACE OF FATHER (city or town): Italy

(State or country)

12 MAIDEN NAME OF MOTHER: Stella Cole

13 BIRTHPLACE OF MOTHER (city or town): Balto Md.

(State or country)

14 Informant: Louis Carbon

(Address): 212 Aiken St.

Filed AUG 1 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-29-27 19

17 I HEREBY CERTIFY, That I attended deceased from 7-29-27 19 , to 7-29 , 19 27

that I last saw him alive on 7-29 , 19 27 ,

and that death occurred, on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Tetanus

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Aspin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial 8/2 1927

20 UNDERTAKER: George J. Ruth ADDRESS: 1735 Harford Ave

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129

E 24391

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2331 W. Lexington ST., 20-69 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna B. Whitlock

(a) RESIDENCE NO. 2331 W. Lexington ST., WARD Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? 62 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: A. J. Whitlock

6 DATE OF BIRTH (month, day, and year): June 16, 1864

7 AGE: Years 62 Months 1 Days 16 If LESS than 1 day, hrs. or min.

63

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Noah Flick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Susana Weingord

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: A. J. Whitlock

(Address): 1927 Eutaw Pl. Hagerstown, Md.

15 Filed 1927 (Day) (Month) (Year) Registrar: Rose M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to July 30, 1927, that I last saw h[illegible] alive on July 30, 1927, and that death occurred, on the date stated above, at 2.35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary): Uremia.

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination.

(Signed) Chas. S. Kerstodt, M. D.

, 19 (Address) 1730 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rose Hill Cemetery Hagerstown Md.

DATE OF BURIAL: Aug. 4 1927

UNDERTAKER: T. Scott Starr

ADDRESS: Ellicott City

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24392

CERTIFICATE OF DEATH.

188-003

E 24392

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 1-3 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer J. Bright

(a) RESIDENCE NO. 725 S. Montford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? 4 yrs. 1 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1923

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	1	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Brest, Md
(State or country)

PARENTS

10 NAME OF FATHER Elmer J Bright
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Delaware City, Del
12 MAIDEN NAME OF MOTHER Johanna Bauer
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Mr. Elmer J Bright
(Address) 725 S Montford Ave

16 Filed ..... 19 .....
AUG 1 1927
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:
Auto. Acc.
Fracture of Skull.
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Shock.
(Duration) ..... yrs. ..... mos. ..... ds.

Signed July 30 1927 G. C. Blades M. D.
(Coroner)
(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Date of Burial 8/2 1927

20 UNDERTAKER Louis Heumann ADDRESS 318 Bway

very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24393

CERTIFICATE OF DEATH.

129

E 24393
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1427 (St.) myrtle ave (Ward) 14-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Alverta Lee

(a) RESIDENCE. No. 1427 myrtle ave St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Lee

6 DATE OF BIRTH (month, day, and year): Oct 31, 1873

7 AGE: Years 53 Months 8 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md Maryland

PARENTS

10 NAME OF FATHER: Samuel Tripp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Trappe Maryland

12 MAIDEN NAME OF MOTHER: Mary Graves

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Quakertech Maryland

14 Informant: Della Howard
(Address): 1427 myrtle ave

15 Filed ... 19...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-20, 1927, to 7-29, 1927, that I last saw h[er] alive on 7-29, 1927, and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

myocarditis

Lymphomum duration from history (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) nephritis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs + symptoms

(Signed) Wm E. L. Lampe, M. D.

7-31, 1927 (Address) 1401 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MC-Auburn — DATE OF BURIAL: Aug 1927

20 UNDERTAKER: Wm. H. Blanchard — ADDRESS: Westminster

THIS IS very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24394

CERTIFICATE OF DEATH

90 ✓ E 24394

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1210 Bolton St., 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Rhodes

(a) RESIDENCE NO. 1210 Bolton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm E. Rhodes

6 DATE OF BIRTH (month, day, and year): September

7 AGE — Years: 86 — Months — Days — IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Benjamin Carrick

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Russell

13 BIRTHPLACE OF MOTHER (city or town): Howard County

(State or country) Md

14 Informant: Emma L. Rhodes

(Address) 1210 Bolton St

15 Filed AUG 1 1927 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1927, to July 29, 1927, that I last saw h[er] alive on July 28, 1927, and that death occurred, on the date stated above, at 11:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) — yrs. — mos. ds.

CONTRIBUTORY (Secondary): Heart

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C. Clark, M. D.

(Address) 2010 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem'y — Date of Burial: 1927

20 UNDERTAKER: John C. Mitchell and Sons — ADDRESS: 1900 Eutaw Place

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Fox.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24395 113 E 24395

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 909 N Twelveth St., 26-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Fox

(a) RESIDENCE NO. 909 N Twelveth St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 8 1926

7 AGE — Years: — Months: 7 — Days: 23 — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER William Fox

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margreth Braley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Washington D.C.

14 Informant: William Fox

(Address): 909 Twelveth St

15 Filed ..... 19.....

Registrar

AUG 1 - 1927 C. HAMPSON JONES, M. D.

By RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1927

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927, to July 30, 1927, that I last saw h alive on July 30, 1927 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Intoxication

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Gastro Intestinal intoxication

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William B Leeman M. D.

Aug 1, 1927 (Address) 718 N Gallows St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — Date of Burial: Aug 1 1927

20 UNDERTAKER: Wendell Dippel Sr — ADDRESS: 378 N

Very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24396 — REGISTERED NO. C — E 24396

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1007 N CHAPEL ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph: Rybak

(Residence in Baltimore: No. 1007 N Chapel St.: 61 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M

4-COLOR OR RACE: W

5-~~SINGLE~~ ~~MARRIED~~ WIDOWED OR ~~DIVORCED~~ (Write the word): WIDOWER

6-DATE OF BIRTH: Jan 16, 1844 (Month) (Day) (Year)

7-AGE: 83 yrs. 6 mos. 14 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): O.D.

9-BIRTHPLACE (State or country): Bohemia

PARENTS

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER (State or country): Dont Know

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (State or country): Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos J. Rybak

(Address) 1607 N. Chapel

15- C. HAMPSON JONES, M. D.

DEC 1927 191 — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July 20, 1927 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 20, 1927, to July 30, 1927, that I saw h/M alive on July 28, 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myo. Cardiitis

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

(Address) 2934 McElderry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Aug 3, 1927

20-UNDERTAKER: Frank Brockson

ADDRESS: 1166 Aliceanna

REGISTERED IN BALTIMORE CITY, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 24397

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24397

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 Cokesbury Ave. ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Peregoy

(a) RESIDENCE No. 618 Cokesbury Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Peregoy

6 DATE OF BIRTH (month, day, and year) March 14, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Abram Bossom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Storms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs A. L. Hunt,

(Address) 618 Cokesbury Ave.

15 Filed AUG 1 - 1927, 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 19 27

17

I HEREBY CERTIFY, That I attended deceased from June 15, 19 27, to July 31, 19 27, that I last saw h[illegible] alive on July 30, 19 27 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

not known

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

duration 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Fair, M. D.

19 (Address) 2704 St. Paul St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grace Cemetery, Balto. Co.	Aug. 2, 1927
20 UNDERTAKER E. Leroy Stiffler	ADDRESS 125 E. North Ave.

Cor.—12-9-25—A Co.—200 Bks.

E 24398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179

E 24398

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hosp. St., 15-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Soulon Parks

(a) RESIDENCE NO. 1347 N. Stricker St. St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Soulon Parks.

6 DATE OF BIRTH (month, day, and year): Unknown 1899.

7 AGE: Years: 28 | Months: | Days: | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): City Coal Co.

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) High Point N. C.

PARENTS

10 NAME OF FATHER Riley Parks.

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Rachel Setbrough

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) N. C.

14 Informant Mrs Soulon Parks.

(Address) 1347 N. Stricker St

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: 3rd. degree burns of body (accidental)

(duration) ____ yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia Bronchial Cough

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Kennedy M. D.

(Coroner)

19____ (Address) 250 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: High Point N. C. Date of Burial: Aug 1 1927

20 UNDERTAKER: Thomas E. Kelson. ADDRESS 1307 Preston St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24399

× 123 E 24399

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Old Fen Road St., 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lottie M. Hill

(a) RESIDENCE NO. Lykesville Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 16 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced, HUSBAND of ~~(or) WIFE~~ of Fred Hill

6 DATE OF BIRTH (month, day, and year): May 5 1898

7 AGE — Years: 28 Months: 8 Days: 26

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Lykesville Md

(State or country)

PARENTS

10 NAME OF FATHER Edward Kroft

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Lykesville Md

12 MAIDEN NAME OF MOTHER Katy Linton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lykesville Md

14 Informant (Fred L. Hill)

(Address) R.F.D. Lykesville Md

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

AUG 1 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to July 31, 1927, that I last saw her alive on July 31, 1927, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Streptococcic Septicemia & cholecystitis following ? gall bladder.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. 9 ds.

18 Where was disease contracted home

if not at place of death?

Did an operation precede death? yes Date of 7/22/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thos. Jones, M. D.

, 19 (Address) Lykesville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Freedom Cemetery

Date of Burial: Aug 3rd 1927

20 UNDERTAKER: C. M. Nutt

ADDRESS: Westminster Md.

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20 4B 24400

E 24400

CERTIFICATE OF DEATH

100-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

City of BALTIMORE: (No.) St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob J. Vinick.

(a) RESIDENCE NO. 136 N. Collington St. Ward Asc - City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Vinick

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Sam - Unknown

11 BIRTHPLACE OF FATHER (City or town) Russia

(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) Russia

(State or country)

14 Informant Friend

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 1 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1927

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1927, to July Aug 1, 1927, that I last saw ~~him~~ alive on Aug 1, 1927, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows: ~~Pneumonia~~ Cardiac failure - Arteriosclerosis ~~Hypostatic~~ Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) ~~Bronchopneumonia~~ Kidney Probably Arteriosclerosis

following (duration) 2 yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of July 27-1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Rehr [illegible]	19
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E. Balt.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24401 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24401

1-PLACE OF DEATH 2524 Keyworth Ave

CITY OF BALTIMORE: (No. 15-58 ST., WARD) 31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Ruskinsky

(a) RESIDENCE NO. 2524 Keyworth Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Ida Ruskinsky

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 45 | Months — | Days — | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Junk dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Ben Ruskinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rebecca Berenbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Rose Ruskinsky (Address) 2454 Keyworth Ave

15 Filed ....., 19 ; RAT Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1926 to Aug 11, 1927, that I last saw h alive on Aug 11, 1927, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

I: Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor L. Levy M. D.

Aug. 19 27 (Address) 2304 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Hebron Cemetery

DATE OF BURIAL: Aug 12 19 27

20 UNDERTAKER: Jack Lowenburg

ADDRESS: Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 24402

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24402

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 54 N Fulton Ave ST. (WARD) 19-27

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Schiere

(a) RESIDENCE NO. 547 N Fulton Ave WARD
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie L Schiere

6 DATE OF BIRTH (month, day, and year): Nov 4 1874

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Paperhanger
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Louis B Schiere
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Annie L Schiere

15 Filed [illegible] 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1926, to July 30, 1927, that I last saw him alive on July 29, 1927, and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma Larynx

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Specimen Exam
(Signed) William S. Love M. D.
, 19 (Address) 7 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 8/2 19 27

20 UNDERTAKER: George A Starky — ADDRESS: Fulton & Fayette

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24403

CERTIFICATE OF DEATH

31

E 24403

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Balto City Hospl St., Ward)

REGISTERED NO. 26-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Ostendorf,

(a) RESIDENCE NO. 1 Balto City Hospl St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 Color or Race W

5 Single, Married, Widowed, or Divorced. (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE Years 53 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (City or town) ?

(State or country)

14 Informant (Address) 1 Balto City Hosp Records

1927 C. HAMPSON JONES, M. D. Registrar

Reg 1580

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to July 27, 1927,

that I last saw h..... alive on July 27, 1927,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pneumonia Bilateral

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tuberculin

(Signed) C. Hampson Jones, M. D.

, 19 1927 1 Balto City Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

AUG 1 1927

Property of the University of Maryland

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24404

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 26-11 WARD) 161-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bruch

(a) RESIDENCE NO. 3404 E Fairmount Ave., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23, 1927

7 AGE Years Months Days 5 1/2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edwin Bruch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Hilda Foreman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Eff ecklam

(Address) Johns Hopkins Hospital

15 Filed 1927 1581 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1927

17

I HEREBY CERTIFY, That I attended deceased from 7-23, 1927, to 7-28, 1927

that I last saw him alive on 7-28, 1927

and that death occurred, on the date stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage
(birth injury)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhagic diathesis of newborn (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eff ecklam, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

19

ADDRESS

C. HAMPSON JONES, M. D.

JOHNS HOPKINS HOSPITAL AUG 1 - 1927

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 24405

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24405

CERTIFICATE OF DEATH.

160

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH #

CITY OF BALTIMORE: No 1132 Woodley ST. 16-22 WARD 7

2-FULL NAME 6 mo old Fortus Tawney

(a) RESIDENCE. No. 1132 Woodley ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) JUL 30 1927

7 AGE Years Months Days If LESS than 1 day 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hurst Tawney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westminster Md

12 MAIDEN NAME OF MOTHER Mary Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster Md

14 Informant Hurst Tawney
Address 1132 Woodley St

15 Filed [illegible], 19 [illegible] M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUL 30 1927 19

17 I HEREBY CERTIFY, That I attended deceased from JUL 30 1927, 19, to JUL 30 1927 19, that I last saw her alive on JUL 30 1927, 19, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Under development
(6 month fortus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? exam

(Signed) Charles E. Bassett, M. D.

, 19 (Address) 1015 Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

C. EMERSON JONES, M. D.

1586 RH

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

(Willett)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24406

E 24406

CERTIFICATE OF DEATH

148

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE (No. Md Gen Hosp St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Willett

(a) RESIDENCE NO. 1526 Compton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 8 mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Walter Willett

6 DATE OF BIRTH (month, day, and year): NOV 19 1905

7 AGE — Years: 21 Months: 8 Days: 10 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: ? Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): ? Unknown

12 MAIDEN NAME OF MOTHER: ? Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Unknown

14 Informant (Address): Husband Friends

15 1927 , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from 7-29-27, 19 to 7-29-27, 19

that I last saw h alive on 7-29-27, 19

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows: Puerperal Septicemia

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos Woodside, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Date of Burial AUG 2 1927

20 UNDERTAKER: John F Denny ADDRESS 715 Cathedral St

C. HARRISON JONES, M.D.

Dep

Very important. See instructions on back of certificates.

Of death in plain terms, so that it may be properly classified. Exact statement of occupation is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24407

CERTIFICATE OF DEATH

E 24407

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2911 Walbrook Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Haller

(a) RESIDENCE NO. 2911 Walbrook Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. 13 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Eugene Haller

6 DATE OF BIRTH (month, day, and year): July 19 1867

7 AGE: Years 60 Months — Days 13

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(r) Name of employer:

9 BIRTHPLACE (city or town): Baltimore city

(State or country) Md

PARENTS

10 NAME OF FATHER Cicero A. Moore

11 BIRTHPLACE OF FATHER (City or town) Ellicott

(State or country) Md

12 MAIDEN NAME OF MOTHER Elinor McClone

13 BIRTHPLACE OF MOTHER (city or town) Balt

(State or country) Md

14 Informant Morris A Moore

(Address) 2911 Walbrook Ave

15 Filed 1927, 19

C. EMERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to Aug 1, 1927, that I last saw h[illegible] alive on July 31 1927, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest D. Rahn, M. D.

Aug 27 19 (Address) 3005 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: 8/3/ 192[illegible]

20 UNDERTAKER: Geo. Weber's Son

ADDRESS: 2503 Edmondson

IMPORTANT—Fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114

E 24408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Berry ST., 13 WARD)

2-FULL NAME Rose Ella Walter

(a) RESIDENCE NO. 802 Berry ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 6 - 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER George Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lussie Lentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant George E. Walter (Address) 802 Berry St

15 Filed [illegible], 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1927

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1927, to July 31, 1927, that I last saw her alive on July 31, 1927, and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows:

Cardio Respiratory failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro Intestinal Intoxication

(not Summer Complaint) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. V. Clift M. D.

8/1, 1927 (Address) 722 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden DATE OF BURIAL Aug 2 1927

20 UNDERTAKER Chenoweth Son Chestnut ALDERMAN

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24409

90 E 24409

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 537 N Washington St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Reynolds

(a) RESIDENCE NO. 537 N Washington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 11 mos. 26 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary A. Reynolds

6 DATE OF BIRTH (month, day, and year) Aug 18. 1849

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	77	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Policeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

161

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Lont Leum

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Lont Leum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Elizabeth Lantz

(Address) 537 N Washington

15 Filed 1927, 19

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 30 1927

17 I HEREBY CERTIFY, That I attended deceased from November, 1926, to July 30, 1927, that I last saw h. alive on July 30, 1927, and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endo-Myocarditis (duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

July 31 1927 (Address) 2005 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Date of Burial Aug 2 1927

20 UNDERTAKER John Lucas ADDRESS Orleans

Be sure all items are properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24410 ✓ 90 E 24410

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 525 N Wolfe St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine M Beck

(a) RESIDENCE NO. 525 N Wolfe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Beck

6 DATE OF BIRTH (month, day, and year) Oct 16 1843

7 AGE Years 83 Months 9 Days 4 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Karl Radenberg

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Koch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Otto

(Address) 525 N Wolfe

15 Filed Aug 3 1927 Registrar RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1927 to July 31 1927, that I last saw h alive on July 31 1927, and that death occurred, on the date stated above, at 4-9 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (Post Rheumatic)

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Decompensation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Ayd, M. D.

Aug 1 1927 (Address) 2605 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem — Date of Burial Aug 3 1927

20 UNDERTAKER John Merrick — ADDRESS 2455 Orleans

IF DEATH IN PAST TEN DAYS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS very important. See instructions on back of certificates.

C. CLARKSON JONES, M. D.

Spec.-7-17-26—A Co.—200 Bks.

E 24411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 24411

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hosp.

City of BALTIMORE: (No. 33d & Calvert Sts St., 9-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Marie Lowenstein

(a) RESIDENCE NO. 623 E 36th St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 hrs ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): August 1, 1927

7 AGE — Years: 0 Months: 0 Days: 8 hrs

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Gerald Lowenstein

11 BIRTHPLACE OF FATHER (City or town): Philadelphia

(State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Edna Kuhl

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md.

14 Informant: Gerald Lowenstein

(Address) 623 E 36th St

15 Filed ..... 19 .....

1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Aug 1, 1927, that I last saw her alive on Aug 1, 19....., and that death occurred, on the date stated above, at 12:45 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. 8 hrs dys

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) Zoe Straight, M. D.

(Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cem — Date of Burial: Aug 2 1927

20 UNDERTAKER: John Ulrich — ADDRESS: 2008 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-27—M&T—500 Blks.

E 24412 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 24412**

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp (WARD) 27-44 REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Anna Worth

(a) RESIDENCE NO. 58 Southern Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 3 mos. 21 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Wilbur Worth

6 DATE OF BIRTH (month, day, and year): April 10, 1901

7 AGE: Years 26 Months 3 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer): Candy Factory

(c) Name of employer: Chocolate Products Co.

9 BIRTHPLACE (City or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Gummer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary McFay

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Baltimore Md.

14 Informant (Address): Hospital Record

15 Filed 1927, 19 Registrar

C. HARRISON JONES, M. D.

Via Penn. Railroad Escort - Mr. Wilbur Worth

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1927

17 I HEREBY CERTIFY, That I attended deceased from July 17 1927 to July 31 1927

that I last saw her alive on July 31 1927

and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Chorea (Sydenham's) 4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Lottie T. Lowe M. D.

(Address) W. Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Havre de Grace DATE OF BURIAL 8/2 1927

20 UNDERTAKER: Henry U. Myers ADDRESS Cor. Eutaw & W. Lafayette Ave

Spec.—1-10-21—M&T—1500 Blks.

E 24413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001 E 24413

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 19-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Miller.

(a) RESIDENCE NO. Westminster R.F.D #3 ST., WARD Westminster. Md.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Hazel miller.

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Redding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital Records

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1927

17

I HEREBY CERTIFY, That I attended deceased from July 30 1927 to Aug 1 1927, that I last saw him alive on Aug 1 1927, and that death occurred, on the date stated above, at 11:35 A m.

The CAUSE OF DEATH* was as follows:

Bilateral Inguinal Hernio-Ileotomy.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Franklin Sq. Hosp.

Did an operation precede death? Yes Date of Aug 1, 27

Was there an autopsy? No.

What test confirmed diagnosis? Observation.

(Signed) W W Mason Walker M. D.

, 19 (Address) Franklin Square Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester Md. DATE OF BURIAL Aug 3 1922

20 UNDERTAKER W M Routson ADDRESS 2538 W North

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

E 24414

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Providence Hospital St., 17 Ward) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Griffith

(a) RESIDENCE NO. 608 W. Hoffman St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F Griffith

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	33	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER W^m Johnson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Harding

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant James F Griffith

(Address) 608 W Hoffman St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 7 19 27 to July 30 19 27

that I last saw h alive on July 30 19 27

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis & Hypostatic Uremia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Ernest C. Laird, M. D.

, 19 (Address) Providence Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Cashmere Cem 8-3 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Eu Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24415

E 24415

CERTIFICATE OF DEATH

1-PLACE OF DEATH Colonial Hospital

City of BALTIMORE: (No. Laurens & Mount St. 14-59 Ward)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roderick Duncan

(a) RESIDENCE NO. 2305 Pennsylvania Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Addie Duncan

6 DATE OF BIRTH (month, day, and year): April 3rd 1902

7 AGE: Years 25 Months 3 Days 28 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER Robert T. Duncan

11 BIRTHPLACE OF FATHER (City or town): N. J.

(State or country)

12 MAIDEN NAME OF MOTHER Addie Wilson

13 BIRTHPLACE OF MOTHER (city or town): ~~Md~~

(State or country): Md

14 Informant (Address): 2305 Pennsylvania Ave Addie Duncan

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-31 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-29, 1927 to 7-31, 1927

that I last saw h~~i~~m alive on 7-31, 1927

and that death occurred, on the date stated above, at 11:33 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Tuberculous Pneumonia)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted? (Baltimore)

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Julius Bialostosky M. D.

. 19 (Address) Colonial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

Date of Burial: May 2 1927

20 UNDERTAKER: Daniel Easton & Co

ADDRESS 916

C. HAMPSON JONES, M.D.

For R.L.L.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 24416

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital H-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John S. Larkins

(a) RESIDENCE NO. 637 Cider alley St. ..... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE Years 23 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Bells-bly

(State or country)

PARENTS

10 NAME OF FATHER John Larkins

11 BIRTHPLACE OF FATHER (City or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Lucy Hooper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14 Informant Lucy Larkins

(Address) 637 Cider all

15 Filed ..... 1927 ..... 16 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-1927

17

I HEREBY CERTIFY, That I attended deceased from 7-27-1927, to 7-31-1927,

that I last saw him alive on 7-31-1927,

and that death occurred, on the date stated above, at 8:30 p m.

The CAUSE OF DEATH* was as follows:

Extravasation of urine - cellulitis of penis, scrotum & perineum,

(duration) ..... yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) urethral stricture.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) L. Jackson, M. D.

7/31, 1927 (Address) 108 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

Date of Burial Aug 2 1927

20 UNDERTAKER Daniel Easton

ADDRESS 446 Pa ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Size—12-23-21—E.B.R.S.—400 Fks.

E 24417

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24417

CERTIFICATE OF DEATH.

161-002

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 802 S. Ellwood Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert E Bowers

(a) Residence No. 802 S. Ellwood Ave Ward.

(Usual place of abode)

Length of residence in city or town where death occurred X yrs. X mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 31, 1927

7-AGE. ..... yrs. ..... mos. 1 ds. If LESS than 1 day, 14 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Robert Edwin Bowers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Frances Macneal

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14- (Informant) Robert E. Bowers

(Address) 802 S. Ellwood Ave

15- Filed Aug 3 1927 C. BAMSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/1/27

17- I HEREBY CERTIFY, That I attended deceased from July 31 1927 to August 1 1927

That I last saw him alive on August 1, 1927

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prolonged Difficult Labor

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. H. Isaacs M. D.

, 19 (Address) 182 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cemetery DATE OF BURIAL. Aug 2, 1927

20-UNDERTAKER. George J. Gould ADDRESS 1532 Hollins St

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.–7-17-26—A Co.—200 Bks.

E 24418

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 24418

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 534 S Bond St. St.. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sebastyan Kwoka

(a) RESIDENCE NO. 534 S Bond St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margarrett Kwoka

6 DATE OF BIRTH (month, day, and year): Jan 18 1874

7 AGE — Years: 53 Months: 6 Days: 12

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Shoemaker

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Poland

PARENTS

10 NAME OF FATHER: Symon Kwoka

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Margarrett Kwoka

(Address): 534 S Bond St.

15 [illegible] 19 1927 C. HAMPSON JONES, M. D. Registrar

Reg'r [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to July 31, 1927, that I last saw h. alive on July 31, 1927, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Laryngitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S

(Signed) John V. Pezdirtz, M. D.

19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — Date of Burial: Aug 3 1927

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank 20

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24419

CERTIFICATE OF DEATH

90

E 24419

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2119 Bank St. St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Tomaszkiewicz

(a) RESIDENCE NO. 2119 Bank St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years 67 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Carpentier

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER John Tomaszkiewicz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mrs Tomaszkiewicz

(Address) 2119 Bank St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 30 1927

17 I HEREBY CERTIFY, That I attended deceased from March 5 1927 to July 30 1927

that I last saw h[illegible] alive on July 30 1927

and that death occurred, on the date stated above, at 430P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Dwan M. D.

July 31 27 (Address) 2211 Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Rosary Aug 3 1927

20 UNDERTAKER — ADDRESS

John M Welch 1803 Bank St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES M. D.

1-1927

0131

Spec.–7-17-26–A Co.–200 Bks.

95 C

2 6 3 E 24420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-001 E 24420

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanette White

(a) RESIDENCE NO. 381 American Av St. Ward Pitts Pa —

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 2, 1921

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	6	29	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa —

(State or country)

PARENTS

10 NAME OF FATHER Harry White

11 BIRTHPLACE OF FATHER (City or town) Pa —

(State or country)

12 MAIDEN NAME OF MOTHER Eliza Hepileam

13 BIRTHPLACE OF MOTHER (city or town) Pa —

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed — 1 - 1927, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-1 1927

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1927, to Aug-1, 1927, that I last saw her alive on Aug 1 —, 1927, and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Congenital hydrocephalus

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? since birth

Did an operation precede death? Yes Date of July 26, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Henry A. Peterson, M. D.

(Address) Johns Hopkins Hosp Balto Md 8/1/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburgh, Pa.

Date of Burial 8/1/27 19

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 W. Balto. St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24421

CERTIFICATE OF DEATH.

129

REGISTERED NO. E 24421

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 206 Warren Ave ST. 22-33 WARD

2-FULL NAME – Catherine E. Fogarty

(a) RESIDENCE. No – 206 Warren Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of – Philip F. Fogarty (deceased)

6 DATE OF BIRTH (month, day, and year) – May 1 – 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER – John Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER – Ellen Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant – Gerald P. Fogarty
(Address) 206 Warren Ave

15 Filed AUG 2 - 1927

16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) – July 29 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1927, to July 29, 1927, that I last saw h alive on July 29, 1927, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Mitchell, M. D.

7/30 1927 (Address) 1277 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: aug 2 1927

20 UNDERTAKER: Margaret L. Flynn ADDRESS: 1422 Light St.

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24422

CERTIFICATE OF DEATH.

179 E 24422

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hosp St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levrada L. Hill

(a) RESIDENCE NO. 1441 Ward St. 21-28 Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colrd

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 11th 1921

7 AGE: Years 5 Months 9 Days 19. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER Levin Hill

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary J Stewart

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Mary J Stewart

(Address) 1441 Ward St

15 Filed Dec 12, 1927 H. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30th 1927

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest and Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Burned

Body burned

(Duration) 24 hrs

CONTRIBUTORY (Secondary) Playing with matches

(Duration) yrs. mos. ds.

(Signed) Thos B. Horton M. D.

(Coroner)

July 30th 1927 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem Laurel Md Date of Burial 19

20 UNDERTAKER: J. A. Brown & Son ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24423 — 129 — E 24423

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 W Lexington ST. 4-26 WARD)

2-FULL NAME Harry Williams

(a) RESIDENCE No. 828 W Lexington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 6 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Rosa Blackstein

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va

14 Informant Rosa Williams (Address) 1029 N Carlton

15 Filed AUG 2 - 1927 19 Registrar C. HAMILTON JAMES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1927

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to July 30, 1927, that I last saw him alive on July 30, 1927, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Cardiac dilatation with Anasarca (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustav Goldman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Aug 2 1927

20 UNDERTAKER John H. Toadvine ADDRESS 1927 Pennsylvania Ave

FROM is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24424

CERTIFICATE OF DEATH

90

E 24424

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Jackson

(a) RESIDENCE No. 2505 Druid Hill Ave St. 13-59 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~[illegible]~~ mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE 77 Years Months Days IF LESS than 1 day hrs. or min.

(From Record)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 040

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Jackson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) (?)

12 MAIDEN NAME OF MOTHER Harriet (?)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Record

15 Filed ..... 19 .....

Registrar

Per RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31 1927

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1927, to July 31, 1927, that I last saw him alive on July 31, 1927, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

Arteria-sclerosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & objective

(Signed) W. W. Chrisman, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Nat. Cemetery aug 3 1927

20 UNDERTAKER — ADDRESS

John H. Toadvine 402 N. Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24425 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 101-001

E 24425

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2235 E Baltimore ST., 1-3 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Feige Dinah Levin

(a) RESIDENCE NO. 2235 E. Baltimore ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Levin

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Ephraim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Bear

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Isaac Levin
(Address) 2235 E Balto St

15 Filed AUG 2 1927, 19 Per R M K Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-1st 1927

17

I HEREBY CERTIFY, That I attended deceased from July 31, 1927, to Aug-1-, 1927, that I last saw h er alive on Aug 1st, 1927, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos Aug ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Herman Seidel M. D.

Aug 1 1927 (Address) 2404 Entaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 8/2 1927

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Balt St

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24426

CERTIFICATE OF DEATH

137 E 24426

REGISTERED NO.

1-PLACE OF DEATH (514 Old Orchard Road)

City of BALTIMORE, (514 Old Orchard St., 28-71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juliet C Thomas

(a) RESIDENCE NO. 514 Old Orchard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 11 mos. 27 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 3. 1854

7 AGE — Years: 72 — Months: 11 — Days: 27 — IF LESS than 1 day ~ hrs. or ~ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Joseph A Thomas

11 BIRTHPLACE OF FATHER (City or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Martha Redgrave

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) —

14 Informant Dr. D. Thomas nephew (Address) 514 Old Orchard Road-Eutaw

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Augt 1 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to Augt 1, 1927, that I last saw her alive on Augt 1, 1927, and that death occurred, on the date stated above, at 7 45 a m.

The CAUSE OF DEATH* was as follows:

Nephritis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystric tumor of ovary

about (duration) 10 yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? 520 Edna Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr. D. Thomas, M. D.

Augt 1, 1927 (Address) 330 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. Date of Burial: Aug 2 1927

20 UNDERTAKER: John O. Mitchell ADDRESS: 1900 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.--12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24427

CERTIFICATE OF DEATH.

113

E 24427

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1608 Walker St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilbert Parker.

(a) RESIDENCE No. 1608 Walker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27th 1924

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Parker

11 BIRTHPLACE OF FATHER (city or town) Carroll Co.

(State or country) Md,

12 MAIDEN NAME OF MOTHER Annie Parker

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co.

(State or country) Md

14 Informant Mary Parker

(Address) 1605 Walker St

15 Filed....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Colitis

(duration) Yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

(Signed) [illegible] M. D.

(Coroner)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. Date of Burial 8/2 1927

20 UNDERTAKER Byron Knight ADDRESS 1218 McElderry St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPART

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24428

E 24428

REGISTERED NO. 114

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 17-24 Ward)

2-FULL NAME Viola Rhuebottom

(a) RESIDENCE NO. 632 Grenville Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race Female colored

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1901

7 AGE Years 26 Months 7 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Daniel Rhuebottom

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Susanna [redacted]

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Susanna Rhuebottom

(Address) 632 Grenville Ave.

15 Filed AUG 2 1927, 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute Dilatation of Heart

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Gastro enteritis

(duration) 5 hrs.

(Signed) O. T. Kennedy M. D.

(Coroner)

1927 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

18 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery Date of Burial Aug 2, 1927

19 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St

AUG 2 1927 HARRY JONES, M. D. Registrar

(Cor.—12-9-25—A Co.—200 Bks.) OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24429

CERTIFICATE OF DEATH

25-95 × 129

E 24429

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Orchard Ave & Fourth St. (Ward) Brooklyn Balto

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Holmgren

(a) RESIDENCE NO. Orchard Ave & Fourth St. (Ward) Brooklyn Balto

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Eliza Holmgren

6 DATE OF BIRTH (month, day, and year): April 19 1866

7 AGE — Years: 61 — Months: 3 — Days: 12 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass worker

(b) General nature of industry, business, or establishment in which employed (or employer): 186

(c) Name of employer: —

9 BIRTHPLACE (city or town) .....

(State or country) Chicago Ills

PARENTS

10 NAME OF FATHER: John Holmgren

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Sweden

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Sweeden

14 Informant: Archie Holmgren

(Address) 4- Orchard Ave

15 Filed AUG 2 - 1927, 19 .....

HAMILTON JONES M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1st, 19 27

17 I HEREBY ~~CERTIFY~~, That I attended ~~deceased~~ from July 6th, 19 27, to Aug 1st, 19 27

that I last saw him alive on July 31st, 19 27,

and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis & chronic interstitial nephritis

(duration) — yrs. — mos. 36 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? Chicago Ill.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed dingnosis? Physical examination

(Signed) Thos. L Carroll M. D.

8/1, 19 27 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial (Aug 3 1927)

20 UNDERTAKER: Robt G Turner Sr. — ADDRESS 1443 N. Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24430

CERTIFICATE OF DEATH.

16-001 E 24430

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1343 Woodyear St.; 15-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aline C Grant

(Residence in Baltimore: No. 1343 Woodyear St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug 7 (Month) (Day), 1926 (Year)

7-AGE, ... yrs. 11 mos. 24 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... child

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, William Grant.

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Elizebeth Young

13-BIRTHPLACE OF MOTHER (State or Country), Balto md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizebeth Grant.

(Address) 1343 Woodyear St

15-

Filed ... 2 ... 1927 ... C. HAMPTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1927, to July 31 1927, that I saw him alive on 7-30, — 1927, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Teething

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. R. Boykin M. D.

..., 191... (Address) 1618 Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetary — DATE OF BURIAL, Aug 2, 1927

20-UNDERTAKER Thomas E. Kelsey — ADDRESS 1503 Preastman St

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24431

CERTIFICATE OF DEATH.

E 24431
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Virginia C. Smith

(a) RESIDENCE NO. Fonerwood Road & Charles St. 12 Ward Non Resident (Georgia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: G. C. Smith

6 DATE OF BIRTH (month, day, and year): 9-28-91

7 AGE: Years 35 Months 10 Days 4 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Georgia

PARENTS

10 NAME OF FATHER Edward Patello

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Maude Simms

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Georgia

14 Informant Union Mem. Hospital
(Address)

15 Filed AUG 2 - 1927 (CHARLESON JONES, M. D.) Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/1 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cyanide Mercury Poisoning
(Suicide)
(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
(duration) .....yrs. .....mos. .....ds.

(Signed) John Mossburg M. D.
(Coroner)

8/2, 1927 (Address) 3632 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs. .....mos. .....ds. In the state .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Atlanta Ga — Date of Burial: Aug 2 1927

20 UNDERTAKER: Wm Flickner & Sons — ADDRESS: North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 24432 Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 24432

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1316 N. Luzerne St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Joseph George Murphy

(a) RESIDENCE NO. 1316 Luzerne St. E. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 DATE OF BIRTH (month, day, and year): July 29 1898

7 AGE — Years: 29 Months: — Days: 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Helper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Baltimore Mfg. Co.

9 BIRTHPLACE (City or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Jas G. Murphy

11 BIRTHPLACE OF FATHER (City or town): Washington D C

(State or country)

12 MAIDEN NAME OF MOTHER: Mary A. Kelly

13 BIRTHPLACE OF MOTHER (City or town): Balto

(State or country)

14 Informant: Mary A. Dalton

(Address) 923 Gramercy Ave

15 Filed 2-1927 19 R.A.J. Registrar

C. H. RICHARDSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1927

17

I HEREBY CERTIFY, That I attended deceased from July 28 1927, to July 31 1927, that I last saw him alive on July 31 1927, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Pleurisy (Con.)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. L. Timmerman M.D.

8/1, 1927 (Address) 2858 Ranford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial 8/4 1927

20 UNDERTAKER: Chas. P. Crane & Son ADDRESS 118 W. Mt. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24433 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24433

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2439 Francis ST. 13-59 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Hill

(a) RESIDENCE NO. 2439 Francis ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Col	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Hill

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Effington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Oscar Hill

(Address) 2439 Francis St

15 Filed ..... 19 ..... Registrar

AUG 1 - 1927 H. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1927, to July 30, 1927, that I last saw her alive on July 30, 1927, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows: Septic Intestinal Infection.

Contributory

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) P. Garland Cuthright M. D.

(Address) 1534 E. H. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	Aug 2, 1927
20 UNDERTAKER Mrs R. G. Elliott	ADDRESS 1725 Ashland Ave

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24434

CERTIFICATE OF DEATH

118-002

E 24434

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 22 N. Penn'l Hospital St., 27-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennette Mullineaux

(a) RESIDENCE NO. 628 N. Arlington Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. Howard Mullineaux

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	69	no	no	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. Y. C.

(State or country)

PARENTS

10 NAME OF FATHER Geo. Donaldson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant E. Howard Mullineaux

(Address) 628 N. Arlington Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug. 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-31, 1927, to 8-1, 1927,

that I last saw her alive on 8-1, 1927

and that death occurred, on the date stated above, at 4:35 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Dangerous Intestinal

(Peritonitis)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? YES Date of 8-1-27

Was there an autopsy? YES

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — Date of Burial Aug 4 1927

20 UNDERTAKER W. Cook — ADDRESS 512 E. Northern

Spec.—1-12-23—M&T—500 Bks.

St. Clair above Bank Sts 3rd Ward

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24435 — CERTIFICATE OF DEATH. — 113 — E 24435

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 South 5th St., 26-31 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Marie Grauroth

(a) RESIDENCE NO. 133 South 5th ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13-1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John R. Grauroth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Minnie Merrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John R. Grauroth
(Address) 133 South 5th St

15 Filed AUG 2 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927, to Aug 1st, 1927.
That I last saw h[illegible] alive on Aug 1st, 1927.
and that death occurred, on the date stated above, at 5.25 P m.

The CAUSE OF DEATH* was as follows:

Acute Entero Colitis.

CONTRIBUTORY (Secondary) Capillary Bronchitis (duration) 3 yrs. 3 mos. 30 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (Aug).

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. McCausland M. D.
(Address) 3508 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dist Carmel — DATE OF BURIAL Aug 3rd 1927

20 UNDERTAKER Tom Cook. — ADDRESS 552 E Nat

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24436

CERTIFICATE OF DEATH

31 E 24436

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1750 E Lombard St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margreth Knorr

(a) RESIDENCE NO. 1750 E Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Knorr

6 DATE OF BIRTH (month, day, and year) Nov 24 1903

7 AGE Years 23 24 Months 8 7 Days 7

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John Lindner

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Josephine Beck

13 BIRTHPLACE OF MOTHER (City or town) Germany

(State or country)

14 Informant Anna Robson

(Address) 1709 N Caston

15 Filed ..... 19.. Registrar

AUG 2 - 1927 For K.K.

(CLINTON JONES, M.D.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1 1927 to July 31 1927

that I last saw h.. alive on July 30 1927

and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Palatins

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Clinton Jones M.D.

(Address) 1709 N Caston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Aug 3 1927

20 UNDERTAKER Randall Appelson ADDRESS 37 Shm

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24437 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24437

CERTIFICATE OF DEATH.

102

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) St Josephs Hospital ST. 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Hilditch

(a) RESIDENCE NO. 1753 N. Gay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 3rd. 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	21	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John Turbert Cotton Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Archer Hilditch.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Eva. Harting.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Eva Hilditch (Address) 1753 N. Gay St.

15 Filed AUG 2 - 1927, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1927

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1927, to July 31, 1927, that I last saw him alive on July 31, 1927, and that death occurred, on the date stated above, at 4:46 p.m.

The CAUSE OF DEATH* was as follows:

Diverticulitis, General Peritonitis

Intestinal Obstruction

Pleuring with Effusion - (Over)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of 7/31/27

Was there an autopsy? yes. Partial.

What test confirmed diagnosis? Clinical & autopsy -

(Signed) H. Laurence Fahrney, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Aug. 3 1927

20 UNDERTAKER Richard F. Lourley ADDRESS 2916 Gorsuch

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24438

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH Edgewood Sanitarium

CITY OF BALTIMORE: (No.) Belloma Ave (ST.) (WARD) 27-48

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maude Griswold Harrison

(a) RESIDENCE NO. Edgewood Sana Belloma Ave (ST.) (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Murray Harrison

6 DATE OF BIRTH (month, day, and year): Aug 4th 1847

7 AGE: Years 79 Months 11 Days 27 If LESS than 1 day, hrs ___ or ___ min

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Florida

PARENTS

10 NAME OF FATHER: Elias Griswold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alabama

12 MAIDEN NAME OF MOTHER: E. M. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mr James F. Turner
(Address) 301 Hilliday St

15 Filed Aug 3 1927 19 C. HAMPSON JONES, M. D. Registrar
Per RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 1 1927

17 I HEREBY CERTIFY, That I attended deceased from July 29 1927, to August 1 1927, that I last saw her alive on August 1 1927, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis -

(duration) Several yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? None -

(Signed) Chamberlaine, M. D.

Aug 2, 1927 (Address) 1327 Park Ave. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: August 3 1927

20 UNDERTAKER: Henry H Jenkins Sons Co

ADDRESS: Oliver and Mt. Clare Sts

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24439 E 24439

CERTIFICATE OF DEATH.

16-003

1-PLACE OF DEATH Mrs Hosp Retreat. REGISTERED NO. 28-63

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Sister) M. Peter Cronin.

(a) RESIDENCE No. Mrs Hosp Retreat ST., ... WARD Manchester N. H.
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) About 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
68	Unknown		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Religious.
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Unknown Ireland

PARENTS
10 NAME OF FATHER Bartholomew Cronin
11 BIRTHPLACE OF FATHER (city or town) Killarney (State or country) Ireland
12 MAIDEN NAME OF MOTHER Catherine Lynch
13 BIRTHPLACE OF MOTHER (city or town) County Kerry (State or country) Ireland

14 Informant Mrs Hosp Records (Address) Mrs Hosp Retreat

15 Filed AUG 2 1927, 19 ... C. HAMILTON JONES, Registrar. Per KKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1924, to Aug 1, 1927, that I last saw h[er] alive on Aug 1, 1927, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:
Chr. Ileo-Colitis
("Dysentery (Unknown)")
(Organism unknown).
(duration) yrs. 1 mos 15 ds.
CONTRIBUTORY (Secondary) Senile Depression Psychosis
Unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) Milton P. Hill, M. D.
, 19 (Address) Mrs Hosp Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester N. H. DATE OF BURIAL July 3 1927

20 UNDERTAKER Stewart & Conmel Co. ADDRESS Balto.

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr. Bladen

E 24440

CERTIFICATE OF DEATH

91-002

E 24440

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3220 Foster ave St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Ebert

(a) RESIDENCE NO. 3220 Foster ave St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Ebert.

6 DATE OF BIRTH (month, day, and year) Jan. 30 1853

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	74	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Geo. Steinberger

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Theresa

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Germany.

14 Informant John Ebert

(Address) 3220 Foster Ave

15 Filed AUG 2 - 1927 Registrar

HERMAN JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1927

17 I HEREBY CERTIFY, That I attended deceased from July 14th, 19..., to July 31, 1927, that I last saw her alive on July 30, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. E. Bladen M.D.

, 19 (Address) 1430 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) N.V.F.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. Date of Burial Aug 3 1927

20 UNDERTAKER Lilly & Geiler ADDRESS 4233 E. Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24441

90 Dr. Rohde

REGISTERED NO. E 24441

1-PLACE OF DEATH

City of BALTIMORE: (No. 928 S. Bouldin St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Berdolt

(a) RESIDENCE NO. 928 S. Bouldin St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Magdelen Berdolt

6 DATE OF BIRTH (month, day, and year): Jan 2nd 1854

7 AGE — Years: 73 — Months: 6 — Days: 29 — IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Butcher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Berdolt

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary M. Berdolt

(Address): 1924 E. Fayette St.

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31st 1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1926 to July 31, 1927

that I last saw him alive on July 31, 1927

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) H. H. Rohde M. D.

19 (Address) 1904 E. Jay. Th. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — Date of Burial: Aug 4 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 4033 Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24442

CERTIFICATE OF DEATH

11-002

1-PLACE OF DEATH 24442

REGISTERED NO. 26-37

City of BALTIMORE: (No. 21 S. Eleventh St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Klingelhofer.

(a) RESIDENCE NO. 21 S. Eleventh St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: Frederick Klingelhofer

6 DATE OF BIRTH (month, day, and year): Oct. 7th 1898

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	28	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Manert Daugvilla

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Hedwig Mitchell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Lithuania

14 Informant: Frederick Klingelhofer

(Address): 21 S Eleventh St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1927, to Aug. 1, 1927

that I last saw her alive on Aug. 1, 1927

and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted? Not known

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. Schumann, M. D.

(Address) 932 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetery — Date of Burial: Aug. 3rd 1927

20 UNDERTAKER: Lilly & Sons — ADDRESS: 4038 Wash. Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

(Veselsky)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24443

E 24443

CERTIFICATE OF DEATH

44

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., Ward) 6-9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Veselsky

(a) RESIDENCE NO. 163 Washington Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE — Years: 59 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bohemia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed 2-1927 19 BALTIMORE CITY HOSPITALS C. HAMILTON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927, to July 27, 1927, that I last saw h. alive on July 27, 1927, and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Sub.

(Signed) C. Hudson Bargel, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — Date of Burial 8-3 1927

20 UNDERTAKER: J. J. Zahez & Sons — ADDRESS 1318 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24444 — CERTIFICATE OF DEATH. — E 24444

REGISTERED NO. 1317

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2203 (St.) Elmora Ave (Ward) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lane

(a) RESIDENCE NO. 2203 Elmora ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND (or) WIFE of Henry C Lane

6 DATE OF BIRTH (month, day, and year) Aug 16 1843

7 AGE — Years 84 — Months 11 — Days 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Mallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Walter Lane

(Address) 2203 Elmora Ave

15 Filed 2 - 1927, 19 — C. HAMPSON JONES, M. D. Registrar

Fee: Rec'd

TION is very important See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1927, to July 31, 1927,

that I last saw h alive on July 31, 1927,

and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Ovarian Tumor

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Senile

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical ex

(Signed) J. M. Lumpkin M. D.

, 19 (Address) 840 S Callaway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. — DATE OF BURIAL 8/3 27

20 UNDERTAKER George A Farley Fallon & Smythe — ADDRESS

Spon.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 16-002

E 24445

REGISTERED NO. E 24445

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Billings

(a) RESIDENCE NO. 335 South Rogers St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male ~~Female~~	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin Billings

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lena Odgen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Lena Billings

(Address) 335 S. Woodyear St.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2. 1927

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927 to Aug 2, 1927.

that I last saw him alive on aug 2, 1927.

and that death occurred, on the date stated above, at 8:9 a. m.

The CAUSE OF DEATH* was as follows:

1) Acute Dysentery

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronco Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Tucker, M. D.

8/2/27 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn Cemetery	8/4/27 19
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

E 24446

Winaker

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 24446

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 1562 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Winaker

(a) RESIDENCE NO. 2813 Boarman Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S. if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Lizzie Winaker

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE — Years: 50 — Months: — — Days: — — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Israel Winaker

11 BIRTHPLACE OF FATHER (City or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rivkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs L. Winaker

(Address) 2813 Boarman ave

15 Filed AUG 3 1927, 19 — H. LINTON JONES, M. D. Registrar

Per R.N.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1927, 19

17 I HEREBY CERTIFY, That I attended deceased from June 6 '27, 19 to Aug 2 '27, 19

that I last saw h— alive on Aug 2 '27, 19

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri - chronic

Cystitis Chronic Pyelitis

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 14 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of June 14 '27

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical findings

(Signed) Emil Novak, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Veteran's Cemetery

Date of Burial: 8/3 19 27

20 UNDERTAKER: Jack Lewis

ADDRESS: 1139 Edmondson

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24447

CERTIFICATE OF DEATH

91-002

E 24447

REGISTERED NO.

1-PLACE OF DEATH Colonial Hospital

City of BALTIMORE: (No. Laurens Mount St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benson Rawlings

(a) RESIDENCE NO. 905 N. Stricker St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Rawlings

6 DATE OF BIRTH (month, day, and year): Aug 30-72

7 AGE — Years: 54 Months: 11 Days: 2 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: Benj Rawlings

11 BIRTHPLACE OF FATHER (City or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Lucy Flor

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Sarah Rawlings

(Address) 905 N. Stricker St

15 Filed AUG 3 - 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per K.M.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7th, 1927, to Aug 2nd, 1927,

that I last saw h. alive on Aug. 1st, 1927,

and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis.

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs developed during last few hrs of life.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Julius Bialostocky M. D.

8-2-1927 (Address) 1122 N Mount St. Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24448 CERTIFICATE OF DEATH. 129 E 24448

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 4-30 WARD)

2-FULL NAME David A Burbage

(a) RESIDENCE NO. Crisfield, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	wh	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pere. R. R.

9 BIRTHPLACE (city or town) (State or country) Deer View Del

PARENTS

10 NAME OF FATHER G. Burbage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. H. C. Burbage (Address) Crisfield Md

15 Filed May 4, 1927 C. B. Collins Registrar

5-3-1927 H. [illegible], M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1927, to May 1, 1927, that I last saw him alive on May 1, 1927, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Uremia - Chronic interstitial nephritis

Bronchopneumonia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophied Prostate (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 21-27

Was there an autopsy? no

What test confirmed diagnosis? Clinically & Operation

(Signed) W. S. Anderson M. D.

. 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Deer View, Del.

DATE OF BURIAL May 5 1927

20 UNDERTAKER Johns A. Bradshaw

ADDRESS Crisfield Md

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24449

CERTIFICATE OF DEATH

31 E 24449

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1419 Eastern av St., 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Bertha Muth

(a) RESIDENCE NO. 1419 Eastern av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Muth

6 DATE OF BIRTH (month, day, and year) March 13. 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	27	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in whirh employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) .....

(State or country) Baltimore County

PARENTS

10 NAME OF FATHER Harry Pitnour

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Frederick Co.

12 MAIDEN NAME OF MOTHER Minnie Pitnour

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Frederick Co.

14 Informant Mrs. M. Witten

(Address) 1419 Eastern ave.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1. 1927.

17

I HEREBY CERTIFY, That I attended deceased from June 5, 1927, to Aug 1, 1927.

that I last saw h[illegible] alive on Aug 1, 1927.

and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? .....

Did an operation preeede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Exam. of Sputum

(Signed) Robt. J. Green M. D.

(Address) 120 Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sweet Air Cemetery — Date of Burial Aug. 4 1927

20 UNDERTAKER George L. Ruth — ADDRESS 1735 Harford ave

...tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24450

CERTIFICATE OF DEATH.

45

E 24450

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 9-17 Ward

2-FULL NAME John Cunningham

(a) RESIDENCE NO. 1738 E. Hoffman Ave. West Drive Garland 65 St. 2 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. Lifetime mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced RUSBAND of (or) WIFE of: Mary Cunningham

6 DATE OF BIRTH (month, day and year): June 18, 1860

7 AGE: Years 67 | Months 1 | Days 13 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Ireland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland.

14 Informant: Mrs. Mary Cunningham

(Address): West Drive Garland P.O.

15 Filed....., 19.....

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug 1 - 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1927, to Aug 1, 1927, that I last saw him alive on Aug 1, 1927, and that death occurred, on the date stated above, at 4 25 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of large intestine (Colon)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/30/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. L. Badaglicacca, M. D.

, 19 (Address) St Agnes' Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial

New Cathedral Cemetery. Aug. 4 1927

20 UNDERTAKER: Geo. J. Ruth ADDRESS 1735 Harford Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 6 1927 HOWARD JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 24451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 24451

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 N. Mount ST. 12-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Georgeanna Adams

(a) RESIDENCE NO. 1403 N. Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Adams.

6 DATE OF BIRTH (month, day, and year) 1-25-~~62~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Randallstown, Md.

PARENTS

10 NAME OF FATHER John Gough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Schenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Gussie Hopkins

(Address) 1403 N. Mount St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31- 1927

17

I HEREBY CERTIFY, That I attended deceased from 7-1- 1927 to 7-31- 1927.

that I last saw her alive on 7-30- 1927,

and that death occurred, on the date stated above, at 7 25 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) George [illegible] M. D.

19 (Address) 1502 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Aug 3 1927

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 3 1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24452

CERTIFICATE OF DEATH. 161-002 E 24452

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1024 Calhoun ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Smallwood Jr

(a) RESIDENCE NO. 1024 Calhoun ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	S

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/3/04.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John W. Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant J.W. Smallwood Jr

(Address) 1024 Calhoun

15 Filed AUG 3 1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/2 1927

17

I HEREBY CERTIFY, That I attended deceased from 7/31, 1927, to 8/2, 1927, that I last saw him alive on 8/2, 1927 and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows:

(a) Carcinoma of Stomach

With Ulceration of Duodenum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Benj Rhett, M. D.

(Address) 1139 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug 3 1927

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Presstman St

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Last residence of deceased. Name of hospital or institution, if any. Street and number. Ward. Length of residence in city or town. Place of birth. Name and birthplace of father. Maiden name and birthplace of mother. Name and address of informant. Date of filing. Signature of registrar. Blank of certificates.

TION is very important See instructions on back o

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24453

CERTIFICATE OF DEATH.

X 49

E 24453

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. J. H. Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Goldfarb.

(a) RESIDENCE NO. Birch Allboy N.J. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cecelia Goedfarb

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Goedfarb

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Morris Goldfarb

(Address) Birch Amboy N.J.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Carcinoma of Bladder

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 1 ds.

(Signed) J. C. Slater M. D.

(Coroner)

Aug 3/27 (Address) 143 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Perth Amboy N.J. Date of Burial Aug 3 1927

20 UNDERTAKER John O Mitchell ADDRESS 80 Eadst Perth Amboy

IF DEATH IS CAUSED BY CRIMINAL ACTION, ACCIDENT OR SUICIDE, NOTIFY CORONER AT ONCE. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Barringer

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24454 × 46 E 24454

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Boringer

(a) RESIDENCE NO. Washingto DC. St. Ward Non Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 29 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid.
(b) General nature of industry, business, or establishment in which employed (or employer): 0'10
(c) Name of employer

9 BIRTHPLACE (city or town) Washington D. C.
(State or country)

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town)
(State or country)
12 MAIDEN NAME OF MOTHER Alice Smith
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Washington D. C.

14 Informant Balto City Hosp.
(Address)

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar
AUG 3 - 1927 RNK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1927, to July 30, 1927, that I last saw h 26 alive on July 30, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Cervix
(duration) Unknown ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Hospital
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) M Alpers M. D.
. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: Aug 3rd 1927

20 UNDERTAKER: A. Jones — ADDRESS: 116 S. Eden

"tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 E 24455

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 524 Lambert ST., 17 WARD) 24

2-FULL NAME Helena Harris.

(a) RESIDENCE NO. 524 Lambert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 3. 1915

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ... min.
11	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas Bright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Minnie Harris

(Address) 524 Lambert St

15 Filed ... 19 Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1927

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927, to July 31, 1927, that I last saw her alive on July 31, 1927, and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculo Peritonitis

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? yes Date of July 31 1927

Was there an autopsy? City Hospital

What test confirmed diagnosis? Physical

(Signed) Henry J Brown, M. D.

July 31 1927 (Address) 916 Cleveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem DATE OF BURIAL: Aug 3 1927

20 UNDERTAKER: Samuel F Hensley ADDRESS 678 Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24456

CERTIFICATE OF DEATH.

162

E 24456

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 bet W. Saratoga St., 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Cottman

(a) RESIDENCE NO. 6 bet W. Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 30-27

7 AGE Years Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Shirley Cottman

11 BIRTHPLACE OF FATHER (City or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Lydia Cottman

13 BIRTHPLACE OF MOTHER (City or town) Va

(State or country)

14 Informant Lydia Cottman

(Address) 6 bet W Saratoga St

15 Filed 1927 C. HAMILTON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Liv

Ex Cause from

(Duration) yrs. mos. 11 hrs.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

July 30 27 (Signed) V C Gladis M. D.

(Coroner)

(Address) 143 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial Aug 3 1927

20 UNDERTAKER Samuel Priestley ADDRESS 578 N Eutaw

If DEATH occurred in a hospital or institution, the NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24457

CERTIFICATE OF DEATH

100-001 E 24457

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hosp St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie May Holt

(a) RESIDENCE NO. 811 Ashland Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 10, 1910

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	17	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country) Md

PARENTS

10 NAME OF FATHER Wm Holt.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Mary Connelly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Walter Holt

(Address) 811 Madison Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug 1, 27

17 I HEREBY CERTIFY, That I attended deceased from 8/1 (8 00 AM 1927 to 8/1 (445 PM 1927

that I last saw h[illegible] alive on 8/1 19[illegible]

and that death occurred, on the date stated above, at 445 P m.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Lacerated perineum & cervix

(duration) yrs. mos 8 wks

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) E E Jacoby M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt. Carmel Cem Aug 4 1927

20 UNDERTAKER — ADDRESS

Wm. P. Elliott 1323 Ashland ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 3 - 1927 H. A. HAMILTON JENKINS, M. D.

Cbr.—12-9-25—A Co.—200 Bks.

E 24458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

202 E 24458

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Nursing Home 5-8 St., Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kirby or Kerby

(a) RESIDENCE NO. 1431 Hunt alley. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	5-4	Mos		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab.

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balt

(State or country) Md

PARENTS

10 NAME OF FATHER Stephen Kirby

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Jno Kirby

(Address) 1431 Hunt Alley

15 Filed ..... 19.. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Vertebra

Dur 2 hrs Shock Accidental

(duration) Struck by Auto.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

, 19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death Dur 2 hrs yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Steuart Cemetery Date of Burial Aug 3 1927

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Ashland Av.

AUG 3 - 1927

Cor. Kirby 1431 Hunt Alley

Fract. Vertebra

Dur 2 hrs Shock Accidental

Struck by Auto.

Mt. Steuart Cemetery Aug 3 1927

Mrs. R. A. Elliott 1725 Ashland Av.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24459 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 24459

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St., 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Franklin

(a) RESIDENCE NO. 1102 Argyle Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Franklin

6 DATE OF BIRTH (month, day, and year): January 1880

7 AGE: Years 47 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town): Virginia

(State or country)

PARENTS

10 NAME OF FATHER: James Franklin

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Eleanor Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Jennie Franklin

(Address): 10 E. 20th St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-31-27 19

17 I HEREBY CERTIFY, That I attended deceased from 7-25- 19 27, to 7-31- 19 27, that I last saw him alive on 7-31- 19 27 and that death occurred, on the date stated above, at 6 00 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach Palliative O

(duration) 6 months ds.

CONTRIBUTORY (Secondary) ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical course

(Signed) Maxwell M. D.

19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: Aug 4 1927

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 125 Oakland Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 3 1927 C. HEALTH DEPT

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24460 — 90 E 24460

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] Ward) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Smith.

(a) RESIDENCE NO. 541 W. Lafayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): ? Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): Unknown ?

7 AGE — Years: 60 — Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Unknown

14 Informant: BALTIMORE CITY HOSPITALS

(Address): [redacted] Reside.

15 Filed AUG 3 1927 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 1/1927

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1925 to Aug. 1, 1927.

that I last saw him alive on Aug. 1, 1927

and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial disintegration

Arteriosclerosis

Hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General Sub.

(Signed) C. Holmes Berry M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Aug 3 1927

Date of Burial

20 UNDERTAKER: Wm. R. Elliott

ADDRESS: 1725 Eastland Ave

HAMILTON JONES, M. D.

Registrar

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 24461 : HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 24461

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2322 Eager Place St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hylock

(a) RESIDENCE NO. 2322 Eager Place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Hylock

6 DATE OF BIRTH (month, day, and year): June 13-1891

7 AGE: Years 36 Months 1 Days 14

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): 69

(c) Name of employer: Duff Bros.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Andrew Zapf

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: C. Meisel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Annie Zapf

(Address) 2322 Eager Place

15 Filed AUG 5 1927 C. HUNTER JONES, M. D. Registrar

By R V K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 Aug 2nd

17 I HEREBY CERTIFY, That I attended deceased from June 1 19 27 to Aug 2 19 27

that I last saw him alive on Aug 1 19

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma of Stomach, Hole epitis adhesions

(duration) 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of July 15/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. Dwyer M. D.

(Address) 1009 Park Ave

8-2-27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Aug 5 1927

20 UNDERTAKER: Jos M. Flanigan & Son — ADDRESS: Baltimore

NOTE—PHYSICIANS, UNDERTAKERS AND INFORMANTS: THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24462 E 24462

CERTIFICATE OF DEATH

147

1-PLACE OF DEATH Bon Secours Hospital REGISTERED NO. 28-64

CITY OF BALTIMORE: (No.) Fayette & Pulaski ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Helen Sorrell

(a) RESIDENCE NO. 1510 Rathland Ave, Forest Park, ST. city. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Milton A Sorrell

6 DATE OF BIRTH (month, day, and year) May 7-1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	2	24.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jos L. Weber.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria.

12 MAIDEN NAME OF MOTHER Christiana Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant Milton A Weber
(Address) 1510 Rathland Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 st 1927

17 I HEREBY CERTIFY, That I attended deceased from July 31 st, 1927, to July 31 st, 1927, that I last saw her alive on July 31 st, 1927, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary oedema

(duration) yrs. mos 24 hrs ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? normal delivery of baby Boy 11.10.27 Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward P. Smith, M. D.

, 19 (Address) 720 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cemetery DATE OF BURIAL 8-4-27.

20 UNDERTAKER M. Fickey & Sons ADDRESS 827 W Lafayette Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

AUG 3 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24463

CERTIFICATE OF DEATH. 188-003 E 24463

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St., 20-27 Ward)

2-FULL NAME John G. Wolf.

(a) RESIDENCE NO. 144 N Fulton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/e yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M Wolf.

6 DATE OF BIRTH (month, day, and year) Feb 27 - 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder

(b) General nature of Industry, business, or establishment in which employed (or employer) Pensioned 04

(c) Name of employer Balto & Ohio RR

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Wolf

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Steiner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary M Wolf

(Address) 1445 N Fulton Ave

15 Filed AUG 5 1927 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

Cardiac Multiple Fractures

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) J C Slader M. D.

(Coroner)

3:50 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial Aug 5 1927

20 UNDERTAKER W J Cook ADDRESS 502 E North

(tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24464

CERTIFICATE OF DEATH.

129

E 24464

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1450 Decatur St. St. 24-35 Ward)

2-FULL NAME Rosina C. Johnson.

(a) RESIDENCE NO. 1450 Decatut St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow.

5a If ~~XXXXX~~ widowed, of ~~XXXXXX~~ ~~XXXXXXXXXXX~~ (or) WIFE of Isaac Johnson.

6 DATE OF BIRTH (month, day, and year) October 8, 1838

7 AGE	Years	Months	Days 24	IF LESS than 1 day.....hrs. or.....min.
	88	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Gent.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Ahlers.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mary Gent. (sister)

(Address) 208 E. Henrietta St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) H. K. Bernard M. D.
(Coroner)

8/3 , 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1450 Decatur Street.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Cemetery	Aug 4 1927
20 UNDERTAKER	**ADDRESS**
William Cook	502 E North Ave

AUG 3 1927 EDWIN JONES M.D.

don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 24465

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] Ward) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME General Lee Perry

(a) RESIDENCE NO. 1148 Argyle Court Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Irene Perry

6 DATE OF BIRTH (month, day, and year): ? 1896

7 AGE — Years: 31 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Georgia

PARENTS

10 NAME OF FATHER General Lee Perry

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Bessie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Georgia

14 Informant BALTIMORE CITY HOSPITALS

(Address) Broadway & E. Monument

15 Filed AUG 3 - 1927, 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31/1927

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to July 31, 1927

that I last saw him alive on July 31, 1927,

and that death occurred, on the date stated above, at 7:05 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic acute

myocarditis, insufficiency of

mitral & aortic interference

Rheumatism (duration) yrs. 2 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General & Local

(Signed) C. Hanson Jones M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Albany Ga — Date of Burial 8/5 1927

20 UNDERTAKER: Judd Easton — ADDRESS 916 Penn

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24466

CERTIFICATE OF DEATH

1/4-001

REGISTERED NO. E 24466

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eulgin Moore.

(a) RESIDENCE NO. 809 Lurman Ann St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ? 1876

7 AGE: Years 51 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 0+0

9 BIRTHPLACE (city or town)

(State or country): Virginia

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): ?

14 Informant: BALTIMORE CITY HOSPITALS

(Address): Catonsville Md

15 Filed ....., 19 .....

Registrar: Ritell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/1/ 1927

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1927 to August 1, 1927 that I last saw him alive on August 1, 1927 and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia - right.
Cerebral hemorrhage - left
Arteriosclerosis. Hypertension

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General - Sulf.

(Signed) C. Stevens Boyd, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Aug 3 1927

20 UNDERTAKER: Daniel Carlson

ADDRESS 916 Druid

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 3 - 1927

Spec.—1-10-21—M&T—1500 Bks.

E 24467 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. ST., 1 WARD) 26-1

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Hemling

(a) RESIDENCE NO. 722 S. Lund ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 19 21

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Balto

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed 3 1921 19 C. HAMPSON JONES M.D. 1587 RRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 19 21

17

I HEREBY CERTIFY, That I attended deceased from July 30, 19 21, to July 31, 19 21, that I last saw h alive on July 30, 19 21, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. THE DAYS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24468

CERTIFICATE OF DEATH 101-001

E 24468

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Baker

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Adam Baker.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed , 19 Registrar

1589

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1926 to July 31, 1927, that I last saw him alive on July 31, 1927, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia - R lower

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Sub.

(Signed) C. Holmes Gwyn, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

IMPORTANT: This certificate should be carefully prepared, and PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24469 ✓

E 24469

CERTIFICATE OF DEATH 113

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Mannion

(a) RESIDENCE NO. 16 South Smallwood st. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 5-10-27

7 AGE: Years — Months 2 — Days 23 — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Thos Mannion

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Agnes Gallagher

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto. Md.

14 Informant: Agnes Mannion

(Address): 16 S. Smallwood.

15 Filed ... 1927 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Aug 3 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25-'27 to Aug 3-'27 19 ; that I last saw him alive on Aug 3-'27 19 ; and that death occurred, on the date stated above, at 7 a.m. The CAUSE OF DEATH* was as follows:

Acute enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Suppuration Salivary Gland

(duration) yrs. mos. 1 hour

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood finding

(Signed) [illegible] M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. — Date of Burial: 8-5, 1927

20 UNDERTAKER: Fielding A. Cole — ADDRESS: 1411 Hollins

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24470

HEALTH DEPARTMENT—CITY OF BALTIMORE E 24470

CERTIFICATE OF DEATH. 86-001

1-PLACE OF DEATH Bon Secour Hospital

CITY OF BALTIMORE: (No. Fayette & Payson Sts ST., 20-27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Herbert L. Biggs

(a) RESIDENCE No. 1910 W. Fairmount Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb.13, 1906

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
21	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Car Repairer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B.&O.R.R.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Oscar E. Biggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Catherine Walters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant (Address) Hospital Record

15 Filed 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1 1927

17 I HEREBY CERTIFY, That I attended deceased from July 0, 19 27 to August 1, 19 27.
that I last saw h alive on August 1, 19 27
and that death occurred, on the date stated above, at 10;30 A.m.

The CAUSE OF DEATH* was as follows:

Otitis Media (Chronic)

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Meningitis Streptococcic (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) Edw O Kendall M. D.

8/3/ 19 (Address) 24 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug. 5 19 27
20 UNDERTAKER	ADDRESS
Bernard C. Hoke	1000 N. Eutaw

3-1927 C. HAMPSON JONES, M. D.

BURIAL SHOULD BE CAREFULLY SUPERVISED. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24471

CERTIFICATE OF DEATH. × 129

E 24471

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 25-72 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Myers

(a) RESIDENCE NO. Fairview Ave Catonsville Md. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Myers.

6 DATE OF BIRTH (month, day, and year) May 2 / 69

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58 yrs.	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles T. Curran

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth N. Evans

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Maryland

14 Informant John W. Myers Jr

(Address) Fairview Ave Catonsville

15 Filed 3-1927 C. HARRISON JONES, M. D., Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2nd 1927

17

I HEREBY CERTIFY, That I attended deceased from May 4th, 1927, to Aug. 2nd, 1927, that I last saw her alive on Aug. 2 1927, and that death occurred, on the date stated above, at 8.45 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. L. Dalaglacca, M. D.

, 19 (Address) St Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

New Cathedral Cemetery Aug 5 1927

20 UNDERTAKER — ADDRESS

Chas B Spence 1328 N. Carrollton Av

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24472

CERTIFICATE OF DEATH

100-001 E 24472

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. 3-4 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hassen

(a) RESIDENCE NO. 723 N. Carolina St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE: Years 70 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0 0 0

(c) Name of employer: R. B. Sparks

9 BIRTHPLACE (city or town): Buffalo

(State or country): N.Y.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: R. B. Sparks

(Address): 722 N. Carolina St.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 2 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to Aug 2, 1927, that I last saw h alive on Aug 2, 1927, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Primary Broncho Pneumonia

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) C. W. Peale, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Cedar Hill Cemetery	Aug 5 1927
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

AS IS.—WRITE PLAINLY, WITH UNFADING INK—PENCIL NOT ACCEPTABLE. ENTRIES ON THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24473 E 24473

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Forest Ave. Hillsdale ST.; 28th WARD)

REGISTERED No. C 90 2465

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Mary Eccles

(Residence in Baltimore: No. Forest Ave. Hillsdale St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Feb. (Month) 9 (Day), 1848 (Year)

7-AGE, 79 yrs. 5 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Christiana, Delaware

PARENTS.

10-NAME OF FATHER, Samuel L. Eccles

11-BIRTHPLACE OF FATHER (State or Country), Milford, Delaware

12-MAIDEN NAME OF MOTHER Mary A. Egbert

13-BIRTHPLACE OF MOTHER (State or Country), Milford, Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. E. Baker

(Address) Forest Ave, Hillsdale

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 2nd (Month) (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 31st 1926, to Aug 2nd 1927, that I saw h[illegible] alive on Aug 2nd 1927, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

and Valvular Heart

Disease (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer

(Duration) 1 yrs. mos. ds.

(Signed) Geo. P. Everhart M. D.

Aug 3rd, 1927 (Address) Woodlawn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL? Via P.R.R. Christiana, Dela. DATE OF BURIAL, Aug. 4th, 1927

20-UNDERTAKER John F. Denny ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

(Mylne)

E 24474

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24474

CERTIFICATE OF DEATH. 7/4-001

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. W. Balto Gen'l Hosp. (STREET) (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Mylne

(a) RESIDENCE NO. Ellicott St. Ellicott City, Md. (If not resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE: Years 68; Months; Days; If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Frank Kirkwood Ellicott City Md.

15 Filed AUG 3 1927 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2 1927 to Aug 3 1927 that I last saw in alive on Aug 3 1927 and that death occurred, on the date stated above, at 3.45P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Cystitis; Pyelitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clin. Exam

(Signed) Louis T. Janvier M. D.

8/3 1927 Address W. Balto Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Cemetery Ellicott City Md. DATE OF BURIAL: Aug 6 1927

20 UNDERTAKER: Levi M. Starr ADDRESS: Ellicott City Md.

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 24475

1 PLACE OF DEATH

CERTIFICATE OF DEATH

45

E 24475

REGISTERED No. C

CITY OF BALTIMORE (No. 1121. Druid Hill Ave St. 11-24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2 FULL NAME Eli Bickman

(Residence in Baltimore: No. 1121. Druid Hill Ave. St.; 53 yrs. mos. ds.)

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 ~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: March 17 (Month) (Day), 1874 (Year)

7 AGE: 53 years. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer, Cement.
(b) General nature of industry, business, or establishment in which employed (or employer): O H O

9 BIRTHPLACE (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lulu H Bickman

(Address) 1121 Druid Hill Ave

15.

Filed AUG 3 1927 C. HAMPSON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug. (Month) 3 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 5th 1927 to Aug 2nd 1927. that I saw him alive on Aug 2 1927, and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Rectum

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Sam'l V. Earle M. D.

Aug 3. 1927 (Address) 1431. Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Essex Co. Va. Bowlus Way

DATE OF BURIAL: 8/5/1927

20 UNDERTAKER: Wm. Lee H. Holland

ADDRESS: 1301 Druid Hill Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24476

CERTIFICATE OF DEATH.

129

E 24476

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 13-59 Ward)

2-FULL NAME Isaac Long

(a) RESIDENCE NO. 1428 Eutaw Place St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 27, 1862

7 AGE: Years 64 Months 9 Days 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER: David Long

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER: Annie Tannebaum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant: Mrs. Mielon Long

(Address) 1428 Eutaw Place

15 Filed_____, 19____ M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/2/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/28/, 1927, to 8/2/, 1927, that I last saw h. alive on 8/2/, 1927, and that death occurred, on the date stated above, at 2.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) .....yrs. .....mos. ?.....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) .....yrs. .....mos. 3.....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jerome A. Askin, M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ohel Shalom Cem. Date of Burial 8/4/ 1927

20 UNDERTAKER: Harid Sondheim ADDRESS 1122 W. Pt. Royal Ave.

...tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24477

CERTIFICATE OF DEATH.

7H-001 E 24477

15-58

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3621 Park Heights Avenue, 15 Ward)

2-FULL NAME Wilhelmina S. Bernstein

(a) RESIDENCE NO. 3621 Park Heights Avenue Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of XXXXXXX Phillip J. Bernstein

6 DATE OF BIRTH (month, day, and year) February 22, 1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) St. Michaels

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Spedden

11 BIRTHPLACE OF FATHER (city or town) Seymour

(State or country) St. Michaels, Md

12 MAIDEN NAME OF MOTHER Margaret Wales

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) St. Michaels, Md.

14 Informant Phillip J. Bernstein

(Address) 3621 Park Heights Ave

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

AUG 3 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) August 1, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Jessup M. D.
Coroner

8/3, 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial 8/4/27 19

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W. ~~Baltimore~~ St

N. B.—WRITE PLAINLY, WITH UNFADING INK. Any error or omission should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24478

CERTIFICATE OF DEATH.

E 24478

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Emerson Hotel St., 4-7 Ward)

2-FULL NAME Thomas L Coleman

(a) RESIDENCE NO. Brooklesville, Md. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose L Coleman

6 DATE OF BIRTH (month, day, and year): Oct 16, 1859.

7 AGE: Years 67 Months 10 Days 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manufacturer Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Bicycle

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Ga

(State or country)

PARENTS

10 NAME OF FATHER: R. Lindsay Coleman

11 BIRTHPLACE OF FATHER (city or town): Ga

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth E Hart

13 BIRTHPLACE OF MOTHER (city or town): Ga

(State or country)

14 Informant: C. M. Lucas

(Address) 100 Amherst Terry

15 Filed ....., 19 ..... By ..... Registrar

AUG 23 1927 NRH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) ~~July~~ August 2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol shot wound in brain

Instantaneous (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Signed: Wilkins (Coroner) M. D.

Aug 2 19 27 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Aug 4 19 27

20 UNDERTAKER: J. M. Cook ADDRESS: 402 E Hart St

CHAS. H. JONES, M. D.

N. B.—WRITE PLAINLY WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24479 ✓ E 24479

CERTIFICATE OF DEATH.

× 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 Hayward ave ST., 27-55 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juanita Louise Crummett

(a) RESIDENCE NO. 818 Hayward ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year): DEC 21-1926

7 AGE — Years: — Months: 7 Days: 13 If LESS than 1 day, hrs. or min.: 12

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) Orange
(State or country) Virginia

PARENTS

10 NAME OF FATHER Elmer E. Crummett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mabel Payne

13 BIRTHPLACE OF MOTHER (city or town) Charlottesville
(State or country) Virginia

14 Informant Mrs. Elmer Crummett
(Address) 818 Hayward ave.

15 Filed , 19 C. HAMPSON JONES, M. D.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1- , 1927, to Aug 3 , 1927,
that I last saw h alive on Aug 2 , 1927
and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Enteritis
Duration (over)
(duration) yrs. mos 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physicians Diagnosis

(Signed) Paul Brown, M. D.
8/3 , 1927 (Address) 1837 Penn. ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Orange, Va — DATE OF BURIAL: Aug 4 1927

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24480

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24480

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2013 Fleet ST., 2-4 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jakub Denski

(a) RESIDENCE NO. 2013 Fleet St ST., WARD ...
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucia Denski

6 DATE OF BIRTH (month, day, and year): [illegible] 1855

7 AGE: Years 72; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Frank Denski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Lucia Denski
(Address): 2013 Fleet

15 Filed AUG 3 1927 By C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 2 19 27

I HEREBY CERTIFY, That I attended deceased from May 1, 19 27, to Aug 2, 19 27, that I last saw h— alive on Aug 2, 19 27, and that death occurred, on the date stated above, at 1930 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Kay Daniel, M. D.

Aug 2 '27 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Aug 4 19 27

20 UNDERTAKER: J W Ozazewski ADDRESS 1934 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24481

CERTIFICATE OF DEATH.

88 E 24481

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital 1-3 St., _____ Ward)

2-FULL NAME Chester Majewskei

(a) RESIDENCE NO. 2217 Essex St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Majewski

6 DATE OF BIRTH (month, day, and year): Sept — 1891

7 AGE — Years: 35 — Months: 11 — Days: ____ — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saloon-

(b) General nature of industry, business, or establishment in which employed (or employer): O-K

(c) Name of employer

9 BIRTHPLACE (city or town): _____

(State or country): Poland

PARENTS

10 NAME OF FATHER: Frank Majewski

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Poland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Poland

14 Informant: Jennie Majewski

(Address): 2217 Essex St

15 Filed _____ 19____ _____ Registrar

AUG 3 1927 C. HAVEN JONES, M. D.

RPS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 1 1927

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1927, to Aug. 1, 1927, that I last saw h~~im~~ alive on Aug 1, 1927, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Cause unknown)

(duration) ____ yrs. ____ mos. 28 ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. J. Knapp, M. D.

8-1-, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Aug 4 1927 — Date of Burial

20 UNDERTAKER: J W. Ozazewski — ADDRESS 1930 Eastern Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24482

CERTIFICATE OF DEATH.

182 E 24482

REGISTERED NO._____

1-PLACE OF DEATH Clyde Steamship Co.

City of BALTIMORE: (No. Battery Ave & York St. St., 22-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hughes.(C)

(a) RESIDENCE NO. 725 Hanover St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	29	---------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore.

(b) General nature of industry, business, or establishment in which employed (or employer) O.K.

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Do not know.

14 Informant Elmer Hughes.(C) cousin.

(Address) 129 N.Hill St.

15 Filed_____ 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
Fall from a scow.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. L. Leonhardt M. D.
(Coroner)

8/3 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — Date of Burial Aug 3 1927

20 UNDERTAKER C L Brandt Son 1700 E. Monument St — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 4 1927 C. BRANDT'S SONS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 24483
1-PLACE OF DEATH

CERTIFICATE OF DEATH. 129 E 24483
REGISTERED NO.

CITY OF BALTIMORE: (No 324 S. Castle ST., 2-4 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret L. Bradyhouse

(a) RESIDENCE No 324 S. Castle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. | 4 COLOR OR RACE W. | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or ~~divorced~~
~~HUSBAND~~ (or) WIFE of James Bradyhouse

6 DATE OF BIRTH (month, day, and year) Apr 5 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	3	26.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Home
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Chas. Feller

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Louise Riehl

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Harry Bradyhouse
(Address) 324 S Castle St

15 Filed AUG 4 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31 1927.

17 I HEREBY CERTIFY, That I attended deceased from 7/27, 1927, to 7/31, 1927.
that I last saw h[illegible] alive on 7/31, 1927
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis & Exhaustion

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage + Heart failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N O Date of

Was there an autopsy? N O

What test confirmed diagnosis? Symptoms + Symptoms

(Signed) Jos D Aisbett, M. D.
, 19 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	8/4/1927
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E. Baltimore St.

S. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. AGE mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24484

CERTIFICATE OF DEATH.

E 24484

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. Fairmount & Broadway St.; 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Hester Keen

(a) RESIDENCE NO. 1720 Nedwood St. Philadelphia Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christopher M. Keen

6 DATE OF BIRTH (month, day, and year): Feb. 28-1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER J. Green.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Margaret Taylor

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Del.

14 Informant A. E. Green

(Address) 708 Edgewood Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1927, to Aug 3, 1927, that I last saw h[e] alive on Aug 3, 1927, and that death occurred, on the date stated above, at 11:56A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Arteriosclerosis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George B Brust, M. D.

(Address) Church Home & Infirmary, Aug 3, 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — Date of Burial: Aug 5 1927

20 UNDERTAKER: George W. Zinkler — ADDRESS: 1737 E. Eager St.

AUG 6 1927 H. PERSON JONES, M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24485

CERTIFICATE OF DEATH.

47

E 24485

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1638 W. Lanvale ST. (WARD) 16-22

2-FULL NAME Johannette Benner

(a) RESIDENCE No. 1638 W. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	2 5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.,

PARENTS

10 NAME OF FATHER: Conrad Benner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Olga Ernie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Conrad Benner
(Address): 1638 W. Lanvale

15 Filed AUG 4 1927 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Aug 3, 1927.

that I last saw h- alive on Aug 2, 1927.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia Hypostatic

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Clarence Grimpler, M. D.

Aug 4, 1927 (Address) 503 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 5 1927

20 UNDERTAKER: Clarence Grimpler — ADDRESS: 503 Scott St.

Spec.—7-17-26—A Co.—200 Bks.

E 24486

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 24486

CERTIFICATE OF DEATH 101-001

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. 735 So. Ann St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ANNA WECHSLER,

(a) RESIDENCE NO. 735 So. Ann St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Paul Wechsler,

6 DATE OF BIRTH (month, day, and year)
September 6-1874.

7 AGE	Years	Months	Days 2
	52	10	26

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession nr particular kind of work House wife,

(b) Genersi nature nf industry, business, nr establishment in which employed (or emplnyer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) German Poland,

PARENTS

10 NAME OF FATHER Joseph Lorbiecki,

11 BIRTHPLACE OF FATHER (City or town) _____
(State or country) German Poland,

12 MAIDEN NAME OF MOTHER Josephine -- ----

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) German Poland,

14 Informant Paul Wechsler, (Husband)
(Address) 735 So. Ann Street

15 Filed AUG 4 - 1927 C. HAMPSON JONES, M. D. Registrar
Per KHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1927, to Aug. 3, 1927, that I last saw her alive on Aug. 3, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Double Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Szydlowski M. D.

. 19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery — Date of Burial Aug. 5- 19 27

20 UNDERTAKER M J. Sadowski — ADDRESS 705 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24487
1-PLACE OF DEATH

CERTIFICATE OF DEATH

161-001 E 24487
REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St., 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Rice

(a) RESIDENCE NO. Baltimore City Hospitals St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — IF LESS than 1 day 4 hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work --

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Nickolas Rice

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Beatrice Dennison

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed AUG 1 1927, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 31, 19 27 to July 31, 1927, that I last saw him alive on July 31, 1927, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth
(5 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. E. Maddux, M. D.

7-31-27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Body disposed of by B.C.H — Date of Burial 8/1 1927

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

See letter in file (Gigliotta) dated 5-3-28 from Vital Statistics Dept

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24488 Antonio Gigliotti

CERTIFICATE OF DEATH

REGISTERED NO. E 24488

1-PLACE OF DEATH

City of BALTIMORE (No. Balto City Hospital St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Tony~~ Antonio Gigliotti Gigliotta

(a) RESIDENCE NO. 715 S Potomac St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): not known

7 AGE: Years 43 Months Days

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waldsman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Italy

(State or country)

PARENTS

10 NAME OF FATHER: Felix Gizioli

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Italy

12 MAIDEN NAME OF MOTHER: Frances ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Italy

14 Informant: Hospital Records

(Address)

15 Filed AUG 4 1927, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927, to August 2, 1927, that I last saw him alive on August 2, 1927, and that death occurred, on the date stated above, at 12 05 P m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis, Peritonitis

Chronic Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 30, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W Bloyce ..., M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Italy Redeemer — Date of Burial: Aug. 4, 1927

20 UNDERTAKER: Wendell & Hoppel — ADDRESS: 300 S Edgar

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Cawady

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24489

CERTIFICATE OF DEATH

38

E 24489

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. President Hosp St., 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Edward Cawady

(a) RESIDENCE NO. 1523 W Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 1 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17, 1927

7 AGE Years Months 2 Days 17 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Born.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James Cawady

11 BIRTHPLACE OF FATHER (City or town) Raleigh N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Almore

13 BIRTHPLACE OF MOTHER (city or town) Ashburn Ga
(State or country)

14 Informant Mother
(Address) 1523 W Lexington

15 Filed AUG 4 1927, 19 Per [illegible] Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1927, to Aug 4, 1927, that I last saw him alive on Aug 4, 1927, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows: Ptomaine

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Malnutrition

(duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. W. Gaines, M. D.

, 19 (Address) President Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Zion

Date of Burial 8-4 1927

20 UNDERTAKER Joseph A Lively

ADDRESS 40 [illegible] Mount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Crowther

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24490 90 E 24490

CERTIFICATE OF DEATH

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO. 14-25

City of BALTIMORE: (No. [redacted] St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Crowther, Jr.

(a) RESIDENCE NO. Lanvale & Greene Sts. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A Crowther ?

6 DATE OF BIRTH (month, day, and year): ? 1857

7 AGE: Years 70 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Dyer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Geo. Crowther, Sr.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England.

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Delaware

14 Informant [redacted]

(Address) Records

15 Filed AUG 4 - 1927 19

C. HAMILTON JONES, M. D. Registrar

Per R.M.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to August 3, 1927

that I last saw h[redacted] alive on August 3, 1927

and that death occurred, on the date stated above, at 2.01 a.m.

The CAUSE OF DEATH* was as follows:

myocarditis chronic & acute hypertension. Enterocolitis. Intest[redacted]

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Sub

(Signed) C. Hamilton Jones, M. D.

A. 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

Date of Burial: Aug 5 1927

20 UNDERTAKER: W M Routson

ADDRESS 223 N Smith

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24491 E 24491

CERTIFICATE OF DEATH. 161-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bowman

(a) RESIDENCE NO. 1531 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Typewriting is preferred. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July - 26 - 27

7 AGE: Years | Months | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elenor Solomon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlotte Virginia

14 Informant E H Peckham

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July - 30 1927

17

I HEREBY CERTIFY, That I attended deceased from July - 26 - 1927, to July - 30 - 1927, that I last saw h alive on July - 30 - 1927, and that death occurred, on the date stated above, at 12:00 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Birth Injury)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E H Peckham, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL AUG 1 1927 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

C. HAMPSON JONES, M. D.

Commissioner of Health

Spec.–7-17-26–A Co.–200 Bks.

E 24492 May 2125

HEALTH DEPARTMENT—CITY OF BALTIMORE E 24492

CERTIFICATE OF DEATH 11-002

REGISTERED NO. 23-32

1-PLACE OF DEATH

City of BALTIMORE: (No. 108 N Randall St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Dunhoff

(a) RESIDENCE NO. 108 N Randall St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helena K. Dunhoff

6 DATE OF BIRTH (month, day, and year): DEC 25 1870

7 AGE: Years 56 Months 7 Days 9

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman of Trains

(b) General nature of industry, business, or establishment in which employed (or employer): B & O. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Matthew Dunhoff

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Agnes Leibich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Helena K. Dunhoff

(Address): 108 N. Randall St

15 Filed AUG 4 - 1927 19 C. LAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-3-1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1927, to Aug. 3, 1927, that I last saw h[illegible] alive on Aug. 3, 1927, and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? [illegible] Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. Co. Date of Burial 8-6 1927

20 UNDERTAKER: Ehrs Harle ADDRESS 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24493

CERTIFICATE OF DEATH

44 E 24493

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2536 E. Baltimore (St.) 6-10 (Ward)

2-FULL NAME Jane B. Tevey

(a) RESIDENCE No. 2536 E. Baltimore ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 4-1877

7 AGE Years 50 | Months | Days 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City P. S. 068

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Michael Tevey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Jennings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick Tevey (Address)

15 Filed , 19 8/2/27 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/2 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-19, 1927, to 8-7, 1927, that I last saw her alive on 8-1, 1927 and that death occurred, on the date stated above, at 8-2-27 4 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma. Stomach - Hip. Bones.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical findings

(Signed) W. B. Moore, M. D.

, 19 (Address) 1402 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pere Lathedal Cem. DATE OF BURIAL 8/5/ 1927

20 UNDERTAKER J. A. Moran ADDRESS 700 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should locate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Moore 1402 Park Ave

Cor —12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24494

CERTIFICATE OF DEATH.

113 E 24494

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 171 Freestman St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerome Boyd

(a) RESIDENCE NO. 171 Freestman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31 1927

7 AGE: Years / Months | Days | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Aug 2, 1927 (Address) 1702 Eutaw Ave

(State or country) Md

PARENTS

10 NAME OF FATHER Samuel Boyd

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Hester McKay

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Samuel Boyd

(Address) 171 Freestman St

15 Filed ..... 19.. C. HANSON JONES, M. D.

Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hic - Colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) no history of injury

(duration) yrs. mos. ds.

(Signed) J. H. Hannan M. D.

(Coroner)

(Address) 1702 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery — Date of Burial: Aug 5 1927

20 UNDERTAKER: Thomas E. Kelsey — ADDRESS: 1303 Freestman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 24495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24495

129

19-27

N. B.—WRITE PLAINLY, WITH LAUNDRY INK. Every question should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 305 N. Fulton Ave., ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Kavanaugh

(a) RESIDENCE NO. 305 N. Fulton Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 18, 1859

7 AGE — Years: 67 68 — Months: 10 — Days: 15 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John J. Kavanaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant John Kavanaugh

(Address) 305 N. Fulton Ave.

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3 1927

17

I HEREBY CERTIFY, That I attended deceased from July 26, 1927 to August 3, 1927, that I last saw her alive on August 3, 1927 and that death occurred, on the date stated above, at 11/30 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 2 Yrs.

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V Kenealy, M. D.

8/4/, 1927 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Aug 6 1927

20 UNDERTAKER: F. A. Wanseck Sons — ADDRESS: 1031 Hanover

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24496

CERTIFICATE OF DEATH.

1/3 E 24496

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 E. Hamburg ST., 23-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Anderson

(a) RESIDENCE NO. 24 E. Hamburg St WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 5, 1927

7 AGE Years Months 5 6 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Stanley W. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Fahey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Stanley W. Anderson

(Address) 24 E. Hamburg

15 Filed AUG 5 - 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/2, 1927, to 8/3, 1927, that I last saw h alive on 8/3, 1927, and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Teething

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Enlarged Colitis

(duration) yrs. mos. 1 ds.

over

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Sweeney M. D.

8/4, 1927 (Address) 910 Eight St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross By H. Sweeney

DATE OF BURIAL Aug 5 1927

20 UNDERTAKER F. A. Krause Son

ADDRESS 703 Hamburg

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24497

CERTIFICATE OF DEATH. X 49

E 24497

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1234 E North Ave ST., 9-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel S Wagner

(a) RESIDENCE NO. 1234 E North Ave ST., 6 WARD York Pa

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Cora Wagner

6 DATE OF BIRTH (month, day, and year): Dec 31-1857

7 AGE — Years: 69 — Months: 7 — Days: 3 — If LESS than 1 day, hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer): Watchman, 61

(c) Name of employer: York Mfg Co,

9 BIRTHPLACE (city or town) (State or country): Adams Co Pa

PARENTS

10 NAME OF FATHER: William Wagner,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Sallie Gayl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Edw. Rost Wagner

(Address) 601 Chestnut St. Balto. Md.

15 Filed AUG 5 - 1927, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 4 1927

17

I HEREBY CERTIFY, That I attended deceased from June 7, 1927, to August 4, 1927, that I last saw him alive on August 4, 1927, and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder (Chronic)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W Whitehead M. D.

, 19 (Address) 2000 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Cemetery York Pa

DATE OF BURIAL: August 14

UNDERTAKER: Thenowerth Son

ADDRESS: 861 Chestnut

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24498

CERTIFICATE OF DEATH.

90

E 24498
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1730 E. Eager ST., 5-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Litzinger

(a) RESIDENCE No. 1730 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29-1903.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	24	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Continental Can Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John M. Litzinger, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary E. Clemens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mary E. Litzinger
(Address) 2510 E. Hoffman St.

15 Filed AUG 5 - 1927 19 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 1 1927 to Aug 4 1927, that I last saw h alive on Aug 3 1927 and that death occurred, on the date stated above, at 6 25 a. m

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Wm Andrew, M. D.

8/4/ 1927 (Address) Mayfair, Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL Aug 8 1927

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E. Eager St.

N. B. WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24499

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 E 24499

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No.) City Hospital St. 8 Ward 40

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony De Orgo

(a) RESIDENCE NO. 3223 Ravenwood St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25 1893

7 AGE — Years: 33 — Months: 8 — Days: 9 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Francesco DeOrgo

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy.

12 MAIDEN NAME OF MOTHER Clara Stella

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Andrea DeOrgo

(Address) 3223 Ravenwood.

15 Filed ..... 19 .....

Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 5 1927 C. HANSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1927

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc.

Fracture of Skull.

(Duration) 7 yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

Aug 4/27 (Signed) F C Pades M. D. (Coroner)

(Address) 1436 Biray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Aug 6 1927

20 UNDERTAKER: Wendell Duff — ADDRESS: 37 [illegible]

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24500

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. E 24500

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST., 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Albaugh

(a) RESIDENCE NO. 4802 Augusta Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth B. Albaugh

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer W. D. Fitzy

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Arthur A Albaugh Son (Address) 4802 Augusta Ave

15 Filed AUG 5 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 1927, to Aug 4th, 1927, that I last saw him alive on Aug 4th, 1927, and that death occurred, on the date stated above, at 1245 Am.

The CAUSE OF DEATH* was as follows:

Hypertension, arterial sclerosis

chronic (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage - Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S A Barranco, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 6th 1927
20 UNDERTAKER William Cook	ADDRESS 504 E North Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Rks.

Tolson

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24501

44

E 24501 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1321 Druid Hill St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle Estella Tolson

(a) RESIDENCE NO. 1321 Druid Hill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jackson Tolson

6 DATE OF BIRTH (month, day, and year) Dec 27, 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	38	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Frank Gardner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Ora Coleman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Jackson Coleman

(Address) 1321 Druid St

15 Filed AUG 5 - 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Aug 4

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1927, to Aug 4, 1927, that I last saw her alive on Aug 3, 1927, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

Coma (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute jaundice

toxemia (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Exp

(Signed) T Wilkerson, M. D.

8/4, 1927 (Address) 1317 Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Md. Date of Burial Aug. 6 1927

20 UNDERTAKER W. Cook ADDRESS 502 N. Wolfe

Spec.—7-17-26—A Co.—200 Bks.

E 24502

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24502

CERTIFICATE OF DEATH

46

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 E. Henrietta St. 22-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J Morgan

(a) RESIDENCE NO. 6 E. Henrietta St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Issac Morgan

6 DATE OF BIRTH (month, day, and year): April 4 1864

7 AGE — Years: 63 Months: 4 Days: — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at

(b) General nature of industry, business, or establishment in which employed (or employer): home

(c) Name of employer

9 BIRTHPLACE (city or town): Cambridge

(State or country): Md

PARENTS

10 NAME OF FATHER: Levin Clark

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louise Bell

13 BIRTHPLACE OF MOTHER (city or [illegible])

(State or country): Maryland

14 Informant: Mrs G.B. Robbins

(Address): 6 E Henrietta st

15 Filed ____, 19__ Registrar

C. HAMPSON JONES, M. D.

AUG 5 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May x, 1927 to Aug 4, 1927,

that I last saw h[illegible] alive on Aug 4th 9.10 1927

and that death occurred, on the date stated above, at [illegible] P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) T. E. Lynch, M. D.

8/5, 1927 (Address) 710 Eutaw pl

*Cause the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md Date of Burial: Aug 5 1927

20 UNDERTAKER: John F Denny ADDRESS: 765 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24503

CERTIFICATE OF DEATH.

74-001 E 24503

REGISTERED NO. 17-24

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1212 Druid Hill Ave St. (Ward)

2-FULL NAME Frank Cole

(a) RESIDENCE NO. 1212 Druid Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) About 1868

7 AGE: Years 58 Months 59 Days 10 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): 10

(c) Name of employer

9 BIRTHPLACE (city or town)..... (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Cole

11 BIRTHPLACE OF FATHER (city or town)..... (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)..... (State or country) Unknown

14 Informant Royal Cole (Address) Woodbine Md

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Hemorrhage

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) .....yrs. .....mos. .....ds.

(Signed) J. [illegible] M. D. (Coroner)

19 (Address) 2802 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem Date of Burial Aug 4 27

20 UNDERTAKER Lawrence Hennelly & Riddle ADDRESS 578

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24504

CERTIFICATE OF DEATH

E 24504

REGISTERED NO. 90 19-24

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McKinney

(a) RESIDENCE NO. 1507 W. Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859 ~~July 2, 1927~~

7 AGE 70 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore Maryland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Brown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Son George McKinney
(Address) 507 W Biddle St

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

Reg

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 7-7, 1927, to 8-2, 1927, that I last saw her alive on 8-2, 1927, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

~~Senility~~ —
Myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY Senility
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) C. Harrison Jones, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem Loraine Co Date of Burial Aug 5 1927

20 UNDERTAKER Samuel F Hawley ADDRESS 578 W Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Bks.

Hall ✓

E 24505 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24505

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Ratter St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Hall

(a) RESIDENCE NO. 1416 Ratter ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of: Adam Hall

6 DATE OF BIRTH (month, day, and year): 1847

7 AGE: Years 70; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: Mrs. Rogers

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Stephen Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mary Davis

(Address): 412 N. Carrollton Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from July 26th 27 to Aug 3rd 1927.

that I last saw her alive on Aug 3rd 1927

and that death occurred, on the date stated above, at 4'30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Chronic

(duration) yrs. mos. 7 ds. 1

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Etz M. D.

, 19 27 (Address) 524 Mon. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Aug 5th 1927

20 UNDERTAKER: Daniel Easley

ADDRESS 916 Baltimore

AUG 5 - 1927 HARRY JONES, M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24506

CERTIFICATE OF DEATH.

74-001

E 24506
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST., (WARD) 17-23
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Carter

(a) RESIDENCE NO. 843 Harlem Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Harriet Carter

6 DATE OF BIRTH (month, day, and year) Mar. 15, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61	60	4	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Private Estate

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Blakey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. H. Carter Jr.
(Address) 843 Harlem Ave.

15 Filed AUG 5 - 1927 19 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2 1927 to Aug. 2 1927, that I last saw h[illegible] alive on Aug 2 1927, and that death occurred, on the date stated above, at 11:00 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage and Hemiplegia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) John A. Gaines, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morning Star Cem. Catonsville

20 UNDERTAKER D. M. Johnson

DATE OF BURIAL 8/5/27

ADDRESS 1284 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Abrams

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24507 — 1-PLACE OF DEATH

CERTIFICATE OF DEATH. 101-001

E 24507 — REGISTERED NO.

CITY OF BALTIMORE: (No.) 202 S. Gilmor ST., 19-28 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Elizabeth Abrams

(a) RESIDENCE NO. 202 S. Gilmor ST., 19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5ft yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Abrams

11 BIRTHPLACE OF FATHER (city or town) Yorkshire
(State or country) England

12 MAIDEN NAME OF MOTHER Ann Conlon

13 BIRTHPLACE OF MOTHER (city or town) Dublin
(State or country) Ireland

14 Informant W. H. Conlon
(Address) 202 S. Gilmor St.

15 Filed AUG 5 1927 By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1927

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1927, to Aug 2, 1927,

that I last saw h alive on Aug 2, 1927

and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill, M. D.

Aug 3, 1927 (Address) 28 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 5 1927
20 UNDERTAKER	ADDRESS
John B. Spence	925 N Caroline St

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A C—200 Bks.

E 24508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 24508

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Chase.

(a) RESIDENCE NO. 614 Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1893

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Richard Chase

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant BALTIMORE CITY HOSPITALS

(Address) Register

15 Filed ....., 19 .....

AUG 5 - 1927 Per ..... Registrar

C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 / 1927

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1927, to Aug 3, 1927, that I last saw h.. alive on Aug 3, 1927, and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

Pulmonary tuberculosis

Tuberculosis peritonitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gram & Smear.

(Signed) C. Arlando Boyd, M. D.

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Olivet Cemetery Bryant Town Charles Co Md	Aug 6 1927
20 UNDERTAKER	ADDRESS
Chas M Olsen	1606 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

E 24509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24509
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1033 W. Lexington ST. 18-26 WARD)

2-FULL NAME Fannie E. Gale.

(a) RESIDENCE NO. 1033 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write this word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Gale.

6 DATE OF BIRTH (month, day, and year) Mar 16 1880

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton Md.

PARENTS

10 NAME OF FATHER Frisby Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Md.

12 MAIDEN NAME OF MOTHER Frances Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Md.

14 Informant Betanita Gale
(Address) 1033 W Lexington

15 Filed AUG 5 1927 HARRY W. JONES, M. D.
Registrar
Per RAC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1927

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1927, to Aug 3, 1927, that I last saw h[illegible] alive on Aug 3, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis
(duration) yrs. one mos. ds.

CONTRIBUTORY (Secondary) Rheumatism.
(duration) yrs. Unknown ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Regular

(Signed) H. Gaffney, M. D.

Aug 4 19 (Address) North Ave & Dennis

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Aug 6 1927

20 UNDERTAKER Mrs. P. A. Elliott — ADDRESS 1725 Ashland Av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26—A Co.—200 Blks.

204948

E 24510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32

E 24510

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Hines

(a) RESIDENCE NO. 1505 Eastern Ave St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 3-26-26

7 AGE — Years: 1 Months: 4 Days: 6 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Frantz Hines

11 BIRTHPLACE OF FATHER (City or town): U-C

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Thomas

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 5 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per RRC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 2 1927

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1927, to Aug 2, 1927, that I last saw h alive on Aug 2, 1927, and that death occurred, on the date stated above, at 8-9 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? 1505 Eastern Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Tuberculin

(Signed) [illegible], M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aslury Cemetery aug 5

Date of Burial 1927

20 UNDERTAKER: McClain Davis

ADDRESS 316 N Eden St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24511

CERTIFICATE OF DEATH.

9

REGISTERED NO. E 24511

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 N. Curley St ST., 6-11 WARD)

2-FULL NAME Helen Fairfax Jones

(a) RESIDENCE NO. 37 N. Curley st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 3, 1925

7 AGE Years	Months	Days 1	If LESS than 1 day, ... hrs. or min.
2	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stay. at Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore city

PARENTS

10 NAME OF FATHER William M. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co. Virginia

12 MAIDEN NAME OF MOTHER Mattie Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. William M. Jones

(Address) 37 N. Curley St.

15 Filed AUG 5 1927, 19 HAMPSON JONES M. D. Registrar

Per —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 , 19.. , to Aug 4 , 19 27 .

that I last saw h alive on Aug 4 , 19 27 .

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) H. M. Curley M. D.

Aug 5 19 27 (Address) 2938 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rappahannock Va

DATE OF BURIAL 7/6 1927

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24512

CERTIFICATE OF DEATH.

E 24512

REGISTERED NO. 16-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U. Balto Gen Hospital (WARD).

2-FULL NAME Henry Jasper

(a) RESIDENCE NO. Glen Arm, Md. ST., WARD

(Usual place of abode) (If outside city limits, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? 65 yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine M. Jasper

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1847

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
79	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ~~Unknown~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARTICULARS

14 Informant Theresa J. Jasper

(Address) 1617 Keyworth Ave.

15 Filed AUG 5 1927 C. HAMPSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1927

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1927 to Aug 4, 1927

that I last saw him alive on Aug 4 1927

and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

General Anasarca 6

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin Exam

(Signed) Louis T. Leary, M. D.

8/4 1927 (Address) W. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Michaels Cemetery

DATE OF BURIAL Aug 7 1927

20 UNDERTAKER Fred'k Lasselmo & Sons

ADDRESS Fulton

X. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24513 ✓ 90 E 24513

CERTIFICATE OF DEATH

E 24513

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 234 N. Chester St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. W. Francis

(a) RESIDENCE NO. 234 N. Chester St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed or divorced HUSBAND of ~~(or) WIFE~~ of Lete Eliza J. Francis

6 DATE OF BIRTH (month, day, and year) Jan 24/32

7 AGE: Years 95 Months 6 Days 10 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Baker

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Thos. Francis

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Mary Ann

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) England

14 Informant Mrs Clara A. Higgins

(Address) 234 N. Chester St.

15 Filed AUG 5 - 1927 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3/27 19

17 I HEREBY CERTIFY, That I attended deceased from June 26 1927, to Aug 3 1927.

that I last saw h.. alive on Aug 2 1927.

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) 75 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Hesser, M. D.

8/14, 1927 (Address) 3901 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

Date of Burial 8/6 1927

20 UNDERTAKER Philip Herwig

ADDRESS 3016 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24514

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24514

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 N. Carrollton ave ST., 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Eidsman

(a) RESIDENCE NO. 712 N. Carrollton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August Eidsman

6 DATE OF BIRTH (month, day, and year): Sept 15th 1857

7 AGE — Years: 69 — Months: 10 — Days: 19 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Carl Schmeil

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eidsmahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas. Eidsman

(Address) 712 N. Carrollton Ave

15 Filed AUG 5 - 1927 19 Registrar: C. HAMPSON JONES M.D.

Per ACB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 3 1927

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Aug. 3, 1927,

that I last saw her alive on Aug. 3, 1927,

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Intercom.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. Hunt C. Blake M. D.

19 (Address) 1014 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ludowick — DATE OF BURIAL: 8/6/27

20 UNDERTAKER: W. J. Lucas & Sons — ADDRESS: Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 24515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 24515

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3140 Leeds St., 20 WARD) 70

2-FULL NAME August Opel

(a) RESIDENCE No. 3140 Leeds St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth Opel

6 DATE OF BIRTH (month, day, and year) February 17, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	16 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Catonsville

(State or country) Maryland

PARENTS

10 NAME OF FATHER Augustus Opel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant C. A. Opel

(Address) 3140 Leeds St.

15 Filed Aug 5 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1927

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1927, to Aug 3, 1927, that I last saw him alive on Aug 3, 1927 and that death occurred, on the date stated above, at 9P m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heat exhaustion

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin & Phy.

(Signed) Fred T. Kyner, M. D.

8/3/27 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 8/6/27 19

20 UNDERTAKER Joseph Cook

ADDRESS 1003 W. Baltimore S

REMEMBER, WRITE IN INK—THIS IS A PERMANENT RECORD. Typewrite if information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-002

E 24516

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1143 W. Hamburg ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Creamer

(a) RESIDENCE NO. 1143 W. Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Creamer

6 DATE OF BIRTH (month, day, and year): April 28. 1867

7 AGE — Years: 60 Months: 3 Days: 7 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: George Kramer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Henrietta Steingang

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): John Creamer 1143 W. Hamburg St

15 Filed AUG 5 1927 19 C. HAMPSON JONES, M. D. Registrar Per ASK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 4 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 30 1927. to Aug 4 1927.

that I last saw her alive on Aug 4 1927.

and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs mos. 2 ds.

CONTRIBUTORY (Secondary): Cardio Sclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) John G. Schwemberg M.D.

19 (Address) 11 No. Arch St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — DATE OF BURIAL: Aug. 6 1927.

20 UNDERTAKER: Mr. Mrs. John N. Teufel & Son — ADDRESS: 801 N. Fayette St.

Spec.—1-12-23—M&T—500 Blks.

E 24517

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24517

CERTIFICATE OF DEATH.

162

REGISTERED NO. 24-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 473 E. Hamburg ST., 24 WARD)

2-FULL NAME Baby Biondo

(a) RESIDENCE NO. 473 E. Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Wh.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 4th 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
				2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Anthony Biondo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Isabella Bocetta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anthony Biona

(Address) 473 E. Hamburg St

15 Filed AUG 5 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1927 to Aug 4 1927 that I last saw h[illegible] alive on Aug 4th 1927 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis D. Palagliano M. D.

, 19 (Address) 711 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent Cem. DATE OF BURIAL Aug 6th 1927

20 UNDERTAKER Frank V. Cipolone ADDRESS 258 E Balto St

Spec.–7-17-26—A Co.—200 Bks.

E 24518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 123 E 24518

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hosp.

City of BALTIMORE: (No. 33rd Hubert St., 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Samuel Brown Thomas

(a) RESIDENCE NO. Not Resident of Balt St. Ward Hanestown, Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Evelyn Thomas

6 DATE OF BIRTH (month, day, and year): 40 yrs old

7 AGE — Years: 40 — Months: 0 — Days: — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): 54

(c) Name of employer: -

9 BIRTHPLACE (city or town): Pa

(State or country)

PARENTS

10 NAME OF FATHER: Daniel C. Thomas

11 BIRTHPLACE OF FATHER (City or town): Pa.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (city or town): Pa

(State or country)

14 Informant: Dr. S. B. Thomas Same

(Address)

15 Filed AUG 5 - 1927, 19 — C. HAMPTON JONES M. D. Registrar

Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5 1927

17 I HEREBY CERTIFY, That I attended deceased from 3- to 5th Aug, to ____, 1927, that I last saw him alive on Thursday, 1927, and that death occurred, on the date stated above, at 1,500 p.m.

The CAUSE OF DEATH* was as follows:

~~acute~~ pulmonary edema

acute pholecystitis

(duration) ____ yrs. ____ mos. 6 ds.

CONTRIBUTORY (Secondary): Bronchio pneumonia + Pulmonary Edema

(duration) ____ yrs. ____ mos. 1 ds.

18 Where was disease contracted if not at place of death? Union Mem. Hosp

Did an operation precede death? yes Date of Aug 3. '27

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) R. J. Bellford, M. D.

8-5-, 1927 (Address) Union memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hanestown, Pa — Date of Burial: Aug 5 1927

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 33 Gallows

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24519

CERTIFICATE OF DEATH

74-001

E 24519

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1112 Whitecoat St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Laura Harris

(a) RESIDENCE NO. 1112 Whitecoat St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: John Harris

6 DATE OF BIRTH (month, day, and year): — — 1874

7 AGE: Years 53 Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town): Anne Arundel Co.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Augustus Green

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Virtus Clark

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant (Address): Mrs. Annie Brown 1112 Whitecoat

15 Filed AUG 5 - 1927 19 C. HARRISON JONES, M. D. Registrar

Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 3rd 1927 to Aug 5th 1927.

that I last saw her alive on Aug 5th 1927.

and that death occurred, on the date stated above, at 4:00 A m.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Hemorrhage

(duration) yrs. 1/2 mos. hrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. E. Ford, M. D.

. 19 (Address) 918 Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: Aug 6th 1927

20 UNDERTAKER: Daniel Easton — ADDRESS 94 Gay St

Spec.—7-17-26—A Co.—200 Bks.

(Wooten)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24520

E 24520

CERTIFICATE OF DEATH

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patsy Wooten

(a) RESIDENCE NO. 1304 Hanover St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-12-95

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	32	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) N-Car

(State or country)

PARENTS

10 NAME OF FATHER Chas. Wooten

11 BIRTHPLACE OF FATHER (City or town) N-C

(State or country)

12 MAIDEN NAME OF MOTHER Nancy Wiley

13 BIRTHPLACE OF MOTHER (city or town) N-C

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1927

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to Aug 4, 1927, that I last saw he alive on Aug 4, 1927, and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Uremia

(duration) Not known yrs. mos. ds.

CONTRIBUTORY —

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? B. Chem Creatinine 19 mg.

(Signed) C. Coates Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

M Lucian Conn Aug 6 27

20 UNDERTAKER Hunt Eastwood ADDRESS 916 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24521

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1314 N. Stricker ST., 15 (WARD) 22 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Randall Williams

(a) RESIDENCE No. 1314 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced: HUSBAND (of) (or) WIFE of: John Williams

6 DATE OF BIRTH (month, day, and year): Mar 4th 1904

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
23	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas Randall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Nellie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Frances Borden

(Address): 1314 N. Stricker St

15 Filed Aug 5 1927, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1927, to Aug 3rd 1927.

That I last saw her alive on Aug 3rd, 1927,

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of the Heart

(duration) 1 yrs. 3 mos — ds.

CONTRIBUTORY (Secondary): Not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 606 N. Biddle St

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) David F. Brown, M. D.

Aug 4th, 1927 (Address) 916 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: Aug 6-1927

20 UNDERTAKER: Daniel Easton | ADDRESS: Penna ave

G. HAMPSON JONES, M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24522

CERTIFICATE OF DEATH.

E 24522

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 102 Clearview Ave. (ST.) Hamilton (WARD) 27-43

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Hentschel

(a) RESIDENCE No 102 Clearview Ave, (ST.) Hamilton (WARD) .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Hentschel

6 DATE OF BIRTH (month, day, and year): Feb. 20. 1859

7 AGE — Years: 68 — Months: 5 — Days: 15 — If LESS than 1 day, hrs. or min.: 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Heinrich Tappe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Richard Hentschel (Son)
(Address) 102 Clearview Ave Hamilton

15 Filed AUG 5 1927, 19.. HAMPSON JONES M. D. Registrar RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 4 1927

17 I HEREBY CERTIFY, That I attended deceased from June 28 -, 19.., to Aug 4 -, 1927.

that I last saw h- alive on Aug 3 -, 1927.

and that death occurred, on the date stated above, at 1.10 p. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Dzg -
(Angina Pectoris)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) 1 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) Thos. O. Brazenor, M. D.

, 19.. (Address) 125 S. Bethany

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — DATE OF BURIAL: Aug 7, 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24523

CERTIFICATE OF DEATH

31 E 24523

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (T.B.) St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Garrison

(a) RESIDENCE NO. 808 S. Belnord ave. St. Ward 1-3

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. T. Garrison

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Devine

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 August 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 20, 19 27, to August 3, 19 27,

that I last saw him alive on August 3, 19 27,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. E. Mathieu M. D.

8-3-. 1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mount Carmel Cemetery	Aug. 6, 1927
20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	1710 Fleet St.

AUG 5-1927

Spec.—1-12-23—M&T—500 Bks.

E 24524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

E 24524

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4007 Fernhill Ave ST.) 15-63 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Schwab

(a) RESIDENCE NO. 4007 Fernhill Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	~~Single~~ Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE Myrtle Schwab

6 DATE OF BIRTH (month, day, and year) 10/14/1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Henry Schwab

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Alan Schwab
(Address) Marlborough Apts

15 Filed ....., 19 ..... Registrar
C. HAMPSON JONES, M. D.
G 5 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/1927

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1925, to 8/4, 1927

that I last saw him alive on 8/4, 1927

and that death occurred, on the date stated above, at 8:35 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 5 mos

18 Where was disease contracted if not at place of death? Ct Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2134 W. Balto st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohev Shalom Cem — DATE OF BURIAL 8/7/1927

20 UNDERTAKER Lenard Sondheim — ADDRESS 119 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24525

CERTIFICATE OF DEATH. 71-001 E 24525

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 7-13 Ward)

2-FULL NAME Mrs. Stella Willer

(a) RESIDENCE NO. Naylors Lane Pikesville Ward Pikesville, Md.

(Usual place of abode)

Length of residence in city or town where death occ 11 ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Charles Willer

6 DATE OF BIRTH (month, day, and year) May 1, 1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER David Kemper

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Solomon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hosp. Records

(Address) Sinai Hosp.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per R C B

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/23 1927 to 8/4 1927, that I last saw h.. alive on 8/4 1927, and that death occurred, on the date stated above, at 7.50 p.m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Cardiac Failure Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of Spinal Fluid

(Signed) Milton Sheden, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. Date of Burial: 8/7/ 1927

20 UNDERTAKER: David Londheim ADDRESS: 115-25 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 5 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24526

CERTIFICATE OF DEATH.

129 E 24526

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 81 Bellevieu ave St. No. 12 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Jacob N. Buchheister

(a) RESIDENCE NO. 81 Bellevieu ave St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Buchheister

6 DATE OF BIRTH (month, day, and year) Nov 8 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER John H. Buchheister

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER E. Knopechneider

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. A. M. Buchheister

(Address) 81 Bellevieu ave

15 Filed _____, 19____ C. HAMPSON JONES, M. D. Registrar

AUG 6 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Aug 3, 1927, that I last saw him alive on Aug 3, 1927, and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. K. Campbell, M. D.

Aug 4, 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Aug 6 1927

20 UNDERTAKER George L. Schwab ADDRESS 401 Fred. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24527

CERTIFICATE OF DEATH.

179 E 24527

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1219 Brentwood St. 25 Ward)

2-FULL NAME Miss Kate Lobus

(a) RESIDENCE NO 1219 Brentwood ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 13-1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50 yrs.	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Gerlach Debus

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Hicks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ger.

14 Informant Mr. Debus

(Address) 1219 Brentwood

15 Filed C. HAMPSON JONES, M. D. Registrar

AUG 6 - 1927 Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3rd, 1927, to Aug. 4, 1927,

that I last saw h.e.r. alive on Aug. 4, 1927,

and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

Accidental Burns - chest, abdomen, thighs, right arm and right side — (Fatal)

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical data

(Signed) A. J. Knapp, M. D.

8-4, 1927. (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem Date of Burial 8/8 1927

20 UNDERTAKER J. F. McCully ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Aug 6 1927 Buried Aug 8 1927 Gerlach Debus

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24528

CERTIFICATE OF DEATH.

51 E 24528

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 413 Hollen Road, Cedarcroft St. 27-16 (Ward)

2-FULL NAME Frank Reginald Baugher

(a) RESIDENCE NO. 413 Hollen Road, Cedarcroft St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 58 yrs. 9 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Oct-12-1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad

(c) Name of employer: B.& O.R.R.

9 BIRTHPLACE (city or town): Reading

(State or country): Penna.

PARENTS

10 NAME OF FATHER John F.Baugher

11 BIRTHPLACE OF FATHER (city or town): Emmintburg

(State or country): Md.

12 MAIDEN NAME OF MOTHER Eva Winchester

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country): Md.

14 Informant: Miss.Florence V.Baugher(sister)

(Address) 413 Hollen Road,Cedarcroft.

15 Filed.....19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

(Coroner)

8/6, 1927 (Address) 3632 Rolandene

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Ceme.Towson,Md. Date of Burial: Aug-6-27

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) ADDRESS: 106 W. North Ave.

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every detail should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

G G 1927 C. HAMILTON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24529

CERTIFICATE OF DEATH

E 24529

1-PLACE OF DEATH Woman's Hospital

City of BALTIMORE: (No. Lafayette & John St. 26-42 Ward)

REGISTERED NO. 154-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bien

(a) RESIDENCE NO. 111 Rasp Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 5. 1927

7 AGE Years Months Days — IF LESS than 1 day 16 hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER David W. Bien

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Lile M DuBois

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Paris France

14 Informant David W. Bien (Address) 111 Rasp Ave Balto Co.

15 Filed ..... 19.. C. HAMPSON JOURS, M. D. Registrar

6-1927 Per BCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 7.50 a.m. Aug 5, 1927, to 12.15 a.m. Aug 6 1927 that I last saw him alive on Aug 6, 1927 and that death occurred, on the date stated above, at 12.15 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. W. Strouse, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem. Date of Burial: Aug 6 19 27

20 UNDERTAKER: Lilly & Zibko ADDRESS: 1038 Wash

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 24530

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24530

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2019 Spruce ST. 7-4 WARD

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Zlotkowski

(a) RESIDENCE. NO. 2019 Spruce ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 27, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4 1/2 mos.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wojciek Zlotkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Strzaska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Zlotkowski
(Address) 2019 Spruce St

15 Filed Aug 6, 1927 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1927, to Aug 5, 1927, that I last saw him alive on Aug 5, 1927, and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia (primary)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 3 hrs. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

8/6 (Signed) Chas J Zeugler, M. D.

(Address) 1401 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug. 8 1927

20 UNDERTAKER J W Ozarowski ADDRESS 1930 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24531

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24531

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph's Hospital St., 12-48 Ward)

2-FULL NAME Catherine L. O'Neill

(a) RESIDENCE NO. 5910 Belona Ave. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 5, 1924.

7 AGE — Years: 3 — Months: 3 — Days: 29 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Harry F. O'Neill

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER L. D. Harrington

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balto. Md.

14 Informant Mrs. L. L. Harrington.

(Address) 5910 Belona Ave

15 Filed_____ 19_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Acc Burns

Matches

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed) C. C. Yates, M. D.

(Coroner)

19 (Address) 1143 E. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Bur. — Date of Burial 8/6 1927

20 UNDERTAKER: Mary M. Wiedefeld — ADDRESS 501 L. 22 St.

G 6 1927 C. HAMPSON JONES, M. D.

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

~~E~~ 24532 (235) — E 24532 (170)

REGISTERED NO. _____

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 1013 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sterling Brown

(a) RESIDENCE NO. 705 - N. Eden St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) Md -
(State or country)

PARENTS

10 NAME OF FATHER Edward Brown

11 BIRTHPLACE OF FATHER (City or town) Md -
(State or country)

12 MAIDEN NAME OF MOTHER Florence Turner

13 BIRTHPLACE OF MOTHER (city or town) Md -
(State or country)

14 Informant Records -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed _____, 19 _____ C. HAMPSON JONES, M. D. Registrar

AUG 6 - 1927 APH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5- 1927

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1927, to Aug 5- 1927,
that I last saw him alive on Aug 5- 1927,
and that death occurred, on the date stated above, at 2 30 P- M.

The CAUSE OF DEATH* was as follows:

acute yellow atrophy of liver

Rheumatic Myocardial disease.

Myocardial insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Van den Bergh - St. Lunet

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Liberty Cem. Harford Co. Md

Date of Burial 8/7/ 1927

20 UNDERTAKER Byron Wright

ADDRESS 1218 McElderry St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24533

E 24533

CERTIFICATE OF DEATH

3/

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (P 9-46 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Rice

(a) RESIDENCE NO. 2635 Boone st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Rice

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Howard Dennis

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Celeste Gassaway

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..., 19 ... C. Hampson Jones, M. D. Registrar

AUG 6 1927

RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 August 5, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1927, to August 5, 1927,

that I last saw her alive on August 5, 1927,

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. E. Madden, M. D.

8-5-1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery Date of Burial 8/8 (27)

20 UNDERTAKER Mrs. Geo. A. Holland ADDRESS 1607 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

2020 E Chase St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24534

CERTIFICATE OF DEATH.

E 24534

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 E - 21 st - ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Laura Gorsuch

(a) RESIDENCE NO. 10 E - 21 st ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jesse Washington

6 DATE OF BIRTH (month, day, and year): March 1, 1864

7 AGE — Years: 63 — Months: - — Days: 27 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Jno Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wm Thomas Gorsuch

(Address) 10 E - 21 st

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5 - 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1927, to Aug 5, 1927,

that I last saw her alive on Aug 5, 1927

and that death occurred, on the date stated above, at 6-10 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis, Chronic Interstitial Nephritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary, Stool.

(Signed) A Woerner, M. D.

8/6, 1927 (Address) 2020 N. Chester

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Alovs

DATE OF BURIAL: Aug 8 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Fort Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK. THIS STATEMENT RECORDS EVENTS OF IMPORTANCE. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24535 — 38 E 24535

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Providence Hospital St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allan Young.

(a) RESIDENCE NO. 525 Bloom St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Child.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 6 - 1926

7 AGE: Years — Months 9 10 Days 29. IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Eugene Young

11 BIRTHPLACE OF FATHER (City or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hortense Layton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elizabeth Young (Address) 525 Bloom St.

15 Filed ..... 19.. C. HAMILTON RILEY, M.D. *Registrar

AUG 7 - 1927 Per RMK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Aug. 5 27

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1927, to Aug. 5, 1927, that I last saw him alive on Aug. 5, 1927, and that death occurred, on the date stated above, at 12:45 p.m.

The CAUSE OF DEATH* was as follows: Pharyngitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Lues

(duration) yrs. mos. ds.

18 Where was disease contracted / if not at place of death? the baby

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis?

(Signed) Robert W. Lantz M. D.

19 (Address) Providence Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Aug 7 19 27

20 UNDERTAKER — ADDRESS

Virginia I. Brooks 1163 Pa. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 24536

E 24536
1-PLACE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 326 Harwood ave St. 47-50 Ward)

2-FULL NAME John J Dunn

(a) RESIDENCE NO. 326 Harwood ave St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. — mos. — ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Kn

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
abt	47	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER John J Dunn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Leary

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs Mary F Givens
(Address) 326 Harwood Ave

15 Filed ....., 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Valvular Disease of Heart
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) John J Dunn M. D.
(Crowner.)
8/6, 1927 (Address) 1632 Poplar ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: Aug 8 1927

20 UNDERTAKER: Henry Hoeck & Son — ADDRESS: 1201 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 24537 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 24537

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1742 E. Preston ST. 8-17 WARD)

2-FULL NAME Frederick G. Hormes

(a) RESIDENCE. No. 1742 E. Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Hormes

6 DATE OF BIRTH (month, day, and year) 12/6/1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Thomas Hormes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lena Hormes

(Address) 1742 E Preston Street

15 Filed AUG 7 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5 - 1927

17 I HEREBY CERTIFY, That I attended deceased from March 24 -, 1926, to Aug. 5 -, 1927, that I last saw h*im* alive on " 5 -, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Extranstown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

, 19 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	8 9 1927

20 UNDERTAKER Albert L. Hitz Jr ADDRESS 1606 N Chester St

H. HAMILTON JONES, M. D.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

58-0014

E 24538 — E 24538

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1810 Aiken st. St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Minnick

(a) RESIDENCE NO. 1810 Aiken St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death ocrurred Life mos. ds. How long in U. S. if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ / Female

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Late Joseph H Minnick

6 DATE OF BIRTH (month, day, and year): Feb 24 1854

7 AGE — Years: 73 — Months: 5 — Days: 11 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in whirh employed (or employer): —

(r) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore (State or country)

PARENTS

10 NAME OF FATHER: John O Brien

11 BIRTHPLACE OF FATHER (City or town): Baltimore (State or country)

12 MAIDEN NAME OF MOTHER: Margaret O Brien

13 BIRTHPLACE OF MOTHER (city or town): Balto (State or country)

14 Informant: Theresa Minnick (Address) 1810 Aiken st

15 Filed ..... 19 ..... Per ..... Registrar

C. HAMPSON JONES, M. D.

AUG 7 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 5 th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 19 26, to Aug 5, 19 27, that I last saw h.. alive on Aug 5, 19 27, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY: .....

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contrarted

If not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood examination

(Signed) Harry Blyde M. D.

8/6, 19 27 (Address) 1100 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer cemetery. Aug. 9 19 27

20 UNDERTAKER: J. Ruth ADDRESS 1735 Hayford av.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24539

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

9 E 24539
REGISTERED NO.

City of BALTIMORE: (No. 1731 N. Montford Ave 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry F. Stuhler

(a) RESIDENCE NO. 1731 N. Montford Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 11 th 27

7 AGE

Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Stuhler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Otilla Loos

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Joseph Stuhler

(Address) 1731 N. Montford Ave

15 Filed AUG 7 - 1927 19 C. H. Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1927, to Aug. 6th, 1927, that I last saw him alive on Aug. 6th, 1927, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Whooping-cough (?) followed by Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Diagnosis

(Signed) J. W. Brown, M. D.

8/7/ 1927 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Baltimore Cem Aug 8 1927

20 UNDERTAKER — ADDRESS

Frank A. Tink 915 N. Gay St

N. B.—WRITE PLAINLY WITH PEN AND INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24540

HEALTH DEPARTMENT—CITY OF BALTIMORE

1884-003

E 24540

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital St. 11-29 Ward)

2-FULL NAME Elsie Fitzpatrick

(a) RESIDENCE NO. 856 Wash Blvd St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 30 1919.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	8	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Thos. J. Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Dorney

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Mary Dorney

(Address) 856 Wash Blvd.

15 Filed _____ 19____ _____ Registrar

For _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock due to Fractured Ribs Pierce Lung

(Duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ___ yrs. ___ mos. ___ ds.

Aug 6/27 (Signed) G. C. Hades (Coroner) M. D.

18 (Address) 143 W. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem Date of Burial 8/8 1927

20 UNDERTAKER J. J. Conan & Son ADDRESS 901 Holl. St

AUG 7 1927 G. Hamilton Jones M. D.

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24541

CERTIFICATE OF DEATH.

90 E 24541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 408 Laurens ST. 14-20 WARD)

2-FULL NAME Solomon Griffin

(a) RESIDENCE NO. 408 Laurens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah Griffin

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 62; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Day Laborer

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Ned Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Minnie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Rezah Sydnor 408 Laurens St

15 Filed . 19 Registrar

AUG 1 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5 1927

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1927, to Aug 5 1927, that I last saw him alive on Aug 5 1927, and that death occurred, on the date stated above at 9 A.M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Indefinite

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Official Ex.

(Signed) R. Garland Upshur M. D.

Aug 5 1927 (Address) 1334 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mausoleum Co Va

DATE OF BURIAL: Aug 7 1927

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Preastman St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24542

CERTIFICATE OF DEATH.

90 ✓ E 24542

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 638 W. Mosher St. 14-20 Ward)

2-FULL NAME Sarah B. Holmes

(a) RESIDENCE NO. 638 W. Mosher St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Color

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced (or) WIFE of: John Holmes

6 DATE OF BIRTH (month, day, and year): July 1849

7 AGE: Years 78 | Months 1 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Lexington

(State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va

12 MAIDEN NAME OF MOTHER: Rachel Bolden

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Hallie Burton

(Address) 638 Mosher St

15 Filed ..... 19 .....

Per ..... Registrar

CHANGES MADE

AUG 7 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/31 19 27

17 I HEREBY CERTIFY, That I attended deceased from 5/7/ 19 27, to 8/31/ 19 27, that I last saw h[illegible] alive on 8/27/ 19 27, and that death occurred, on the date stated above, at 10.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Holmes M. D.

(Address) 912 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem Aug 7 1927

20 UNDERTAKER: Samuel H. Hemsley

ADDRESS 578 Biddle

AFTER LEARNING WITH CAPABILITY—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24543

1-PLACE OF DEATH

REGISTERED NO. 1 12 E 24543

City of BALTIMORE: (No. 3122 E Lombard St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert A. Hall

(a) RESIDENCE NO. 3122 E; Lombard St. I Ward

(Usual place of abode) 46

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Knoche

6 DATE OF BIRTH (month, day, and year) November 9 th 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	46	8	27 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank Messenger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Mrs Ida Hall

(Address) 3122 E; Lombard St

15 Filed C. HAMILTON JONES, M. D. 19

AUG 7 - 1927 By R M G Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5 th 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 19 to Aug 5 19

that I last saw him alive on Aug 5 19

and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Secondary

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chest

(Signed) H. Hamilton Jones M. D.

8-6-27 19 (Address) 2938 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — Date of Burial Aug 8 1927

20 UNDERTAKER John Merrick — ADDRESS 2 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24544

CERTIFICATE OF DEATH.

197 E 24544

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Universtiy Hospital St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Francis Doehler

(a) RESIDENCE NO. 1838 W. Mulberry Street St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? 33 yrs. 11 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frances Doehler

6 DATE OF BIRTH (month, day, and year) Aug-14-1893

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	33	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police

(b) General nature of industry, business, or establishment in which employed (or employer) Policing

(c) Name of employer City of Balto.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Traugott Doehler

11 BIRTHPLACE OF FATHER (city or town) ? ?

(State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Jacobs

13 BIRTHPLACE OF MOTHER (city or town) ? ?

(State or country) Germany

14 Informant Mrs. Frances Doehler (wife)

(Address) 1838 W. Mulberry Street.

15 Filed AUG 7 1927 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 192 7

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Homicide
Gun Shot Wound of Chest

(Duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) hrs. mos. ds.

Aug 5 1927 (Signed) C. C. Bridges M. D.
(Coroner)

19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death? ———

Former or usual residence ———

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Aug 8 1927

20 UNDERTAKER [illegible] COMPANY ADDRESS

WILLIAM F. WOODEN, Successor

...ason of Informa... ...ld state CAUSE OCCUPATION is

...S A PERMANENT REC... ...tated EXACTLY. PHYSI... ...erly classified. Exact st... ...ificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24545

E 24545

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1619 Laurens St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Knight

(a) RESIDENCE NO. 1619 Laurens St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colrd

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 25, 1907

7 AGE — Years: 19 — Months: 7 — Days: 11

If LESS than 1 day ....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Virginia

(State or country)

PARENTS

10 NAME OF FATHER: W... Yancy

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Nannie Obey

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

14 Informant: E. M. Chase

(Address): 1400 Mosher St.

15 Filed ..... 19.... Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 5 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) no other known

(duration) ....yrs. ....mos. ....ds.

(Signed) D. C. Jones M. D.

(Coroner)

Aug 6, 1927 (Address) 280 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hardings Ch. Va. Date of Burial: Aug 7 1927

20 UNDERTAKER: Wm. H. Chase Son ADDRESS: Woodbine

AUG 7 1927 BALTIMORE, MD.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24546

CERTIFICATE OF DEATH

100-001

E 24546

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. 4125 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Brooke

(a) RESIDENCE NO. 107 Arch St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 28-25

7 AGE Years: 2 Months: 4 Days: 8

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None (Child)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Arthur Moore

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Missouri

12 MAIDEN NAME OF MOTHER: Charistian Worley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Christian Worley

(Address) 107 Arch St.

15 Filed ..... 19 ..... Registrar

C. HARRISON JONES, M. D.

AUG 7 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5 1927

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927, to Aug 5, 1927

that I last saw her alive on Aug 5, 1927

and that death occurred, on the date stated above, at 1:00 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Lawes, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Ft Lincoln Cem	Aug 7 1927
20 UNDERTAKER: Ernest Pree	ADDRESS: 6648 Fairmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24547

90 E 24547

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 Aliceanna St. ST 2-4 WARD)

2-FULL NAME Mary K Walters

(a) RESIDENCE NO. 1826 Aliceanna St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Walters

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Bolek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemian

12 MAIDEN NAME OF MOTHER Katherine Shendezez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemian

14 Informant Henry Walters

(Address) 1826 Aliceanna St.

15 Filed AUG 7 - 1927 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 31 1927, to Aug 4 - 1927.

that I last saw her alive on 1927

and that death occurred, on the date stated above, at 1235 a m

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility Anemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick W Thomsen M. D.

(Address) 2913 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Aug	8 1927

20 UNDERTAKER John C. Miller ADDRESS 2435 E Oliver

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24548 PLACE OF DEATH

113 E 24548 REGISTERED NO.

City of BALTIMORE: (No. 421 S Chester St St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Szymanski

(a) RESIDENCE NO. 421 S Chester St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	5		27	15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Zygmind Szymanski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Philadelphia Pa.

12 MAIDEN NAME OF MOTHER Mary Barkowska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Elkridg

14 Informant Zygmind Szymanski

(Address) 421 S Chester St.

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from July 31st, 19 27, to Aug 6th, 19 27.

that I last saw her alive on ....., 19 27.

and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) same

(duration) ..... yrs. mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Nicol L Wesner, M. D.

8 7 : 1927 (Address) 30 S Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Rosary Cem	Aug. 8 1927

20 UNDERTAKER John M Weber ADDRESS 803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24549 — REGISTERED NO. E 24549

X118-002

1-PLACE OF DEATH Univ. Hospital

City of BALTIMORE: (No. 4-30 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Seivert

(a) RESIDENCE NO. Laurel, Maryland St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of infant

6 DATE OF BIRTH (month, day, and year) April 5 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
		4.	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer

9 BIRTHPLACE (city or town) Laurel

(State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest L. Seivert

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Jessen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Cecil Maryland

14 Informant Lewis C. Seivert

(Address) Laurel Md

15 Filed ..., 19 ... Registrar

AUG 7 - 1927 RM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 19 27, to Aug 6, 19 27,

that I last saw h... alive on Aug 6, 19 27.

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Intussusception

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Aug 1927

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. S. Anderson, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Laurel Md	Aug 7 19 27
20 UNDERTAKER	ADDRESS
L Lloyd Kaiser	Laurel Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–1 Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24550

REGISTERED NO. E 24550

1-PLACE OF DEATH

City of BALTIMORE: (No. 2206 Maryland Ave. Ward 90)

2-FULL NAME Lillie Schnauffer

(a) RESIDENCE NO. 2206 Maryland Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 65 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: Wm Schauffer

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Elise Moose

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs Elise Hirschman

(Address) 2238 Edgevale Rd

15 Filed ..... 19 ..... Per ..... Registrar

AUG 7 1927 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6 1927 to Augt 5 1927 that I last saw her alive on Augt 4th 1927 and that death occurred, on the date stated above, at 6:45 a. m.

The CAUSE OF DEATH* was as follows:

Mitral heart disease

about

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Balto Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? mitral systolic murmurs extensive consolidation of left scapula area & general cachexia.

(Signed) Jas. McCullough, M. D.

Augt 6, 1927 (Address) Balto. Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Aug 8 1927

20 UNDERTAKER: John J Mitchell — ADDRESS: Aug 8 1927 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24551 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24551

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 Wiconico ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Magersupp.

(a) RESIDENCE NO. 1139 Wiconico ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 17. 1862

7 AGE: Years 65 Months 0 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Loader of Booms

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm. Magersupp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Louisa Schlag.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant (Address) Mrs. Mary M. Murphy. 1139. Wiconico St

15 Filed. 8 1927. 19 Registrar RRK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1927.

17 I HEREBY CERTIFY, That I attended deceased from May 1. 1927. to August 6. 1927. that I last saw him alive on August 6. 1927. and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (Uremia)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Davis M. D.

, 19 (Address) 1117 Mosher Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. DATE OF BURIAL: Aug 8 1927.

20 UNDERTAKER: J.M. Mrs. John M. Crufel & Son ADDRESS: 801 W. Fayette

C. HAMPSON JONES, M. D.

AUG 8 1927

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24552

CERTIFICATE OF DEATH.

E 24552

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 705 Woodbourne Ave. St., 27-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William Warner Abbott

(a) Residence No. 705 Woodbourne Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred- yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-CONDITION, Single, Married, Widowed, Divorced, (Write the word.): widower

5a-If married, widowed, or divorced, HUSBAND or WIFE of: E. Jeanette Miner Abbott

6-DATE OF BIRTH (month, day and year): Mch. 9. 1856

7-AGE: 71 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Bank clerk
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: John W. Abbott

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Maryland

12-MAIDEN NAME OF MOTHER: Mary F. Hall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.

14-(Informant): Miss Julia Abbott
(Address): 705 Woodbourne Ave

15-Filed AUG 8 - 1927, 192.. Registrar. CLARENCE JONES, M. D. RKK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): August 5. 1927

17- I HEREBY CERTIFY, That I attended deceased from July 3rd, 1927 to Aug 5, 1927.

that I last saw him alive on Aug 5, 1927.

and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan M. D.

Aug 6, 1927 (Address) 5104 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Aug. 8. 1927

20-UNDERTAKER: Hughes & Jones Inc — ADDRESS: 424 N. Broadway

Should be carefully supplied. All should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Esther Muckle.

Spec.-7-17-26-A Co.-200 Blks.

E 24553

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24553

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 12-50

City of BALTIMORE: (No. 3 3rd St. (Calvert) St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. (Willard) D. Muckle

(a) RESIDENCE NO. 59 Brunswick ave St. Ward Jersey City N.J.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced (or) WIFE of W. D. Muckle

6 DATE OF BIRTH (month, day, and year) 10-29-1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. J.

PARENTS

10 NAME OF FATHER John Bennett

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N.J.

12 MAIDEN NAME OF MOTHER Lousa Gordon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N.J.

14 Informant Union Memorial Hospital

(Address) 33rd & N. Calvert St.

15 Filed Aug 8 19 27 R. Hall Registrar

Escort Dr. Bennett via Penn. R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from aug 6, 1927, to aug 7, 1927, that I last saw her alive on aug 7, 1927, and that death occurred, on the date stated above, at 4.50 p m.

The CAUSE OF DEATH* was as follows:

acute appendicitis, diffuse inflammation of Caecum

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Post Operative Bronchio pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 8-6-27

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) R. J. Bellford M. D.

8-7-27 19 (Address) Union mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cobleskill N.Y. Date of Burial 9/8/27 19

20 UNDERTAKER Henry A. Mears & Sons ADDRESS 805 N. Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24554

CERTIFICATE OF DEATH.

E 24554

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1124 (Street) Druid Hill Ave (Ward) 21-31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Scurry

(a) RESIDENCE NO. 1124 Druid Hill Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) September

7 AGE Years 16 Months Days If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Henry Scurry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant Henry Scurry

(Address) 1124 Druid Hill Ave

15 Filed Aug 8 1927 C. HUBERT JONES, M. D. Registrar

Per —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6. 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25 1927 to Aug 6 1927.

that I last saw him alive on Aug. 4 1927

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Pullinger M. D.

Aug 6. 1927 (Address) 686 Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Aug 8 1927

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Lanvale St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24555

CERTIFICATE OF DEATH.

E 24555

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 603 Brookwood Road (ST.) Hunting Ridge (WARD) 28-66

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard P. Muse

(a) RESIDENCE NO. 603 Brookwood ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna Sheffield Muse

6 DATE OF BIRTH (month, day, and year) Jan 23 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	59	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel W. Muse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Purcell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. B. P. Muse (Address) 603 Brookwood Rd.

15 Filed AUG 8 1927 19 ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6. 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1. 1926. to Aug. 6. 1927. that I last saw him alive on Aug. 5. 1927. and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Lympho-Sarcoma

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? — No.

What test confirmed diagnosis? X-Ray —

(Signed) Martin F. Sloan M. D.

8.6.1927 (Address) 415 Prof. Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. | DATE OF BURIAL Aug 8 1927

20 UNDERTAKER Chas. E. Franck | ADDRESS 802 Madison Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 320 Maryland (ST.) (WARD)

REGISTERED NO. 25532

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raynold C. Stiles Jr.

(a) RESIDENCE NO. 320 Maryland Ave (ST.) Westport WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14, 1927

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Reynold C. Stiles

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Catherine White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mr. Reynold Stiles Sr.

(Address) 320 Md. Ave Westport

15 Filed AUG 8 1927, 19 .. Registrar R H K

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1927

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1927, to Aug 6, 1927, that I last saw h[illegible] alive on Aug 5, 1927, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Both

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 51 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Aug 8 1927

20 UNDERTAKER: Nelson E. Stiles — ADDRESS: 320 Md. Ave Westport.

IMPORTANT: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

205402 E 24557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 24557

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H- Cross

(a) RESIDENCE NO. 1225 N. Bond St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Christina Cross

6 DATE OF BIRTH (month, day, and year) Jan 23/72

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	55	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinkman

(b) General nature of industry, business, or establishment in which employed (or employer) Coca Cola Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Md -

(State or country)

PARENTS

10 NAME OF FATHER Frank Cross

11 BIRTHPLACE OF FATHER (City or town) Md -

(State or country)

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md -

(State or country)

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 8 1927, 19 C. HAMPSON JONES, M. D. Registrar

By R. C. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1927, to Aug 6, 1927, that I last saw him alive on Aug 6, 1927, and that death occurred, on the date stated above, at 3 45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Bright's Disease

Arteriosclerosis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Lung infection

(duration) yrs. mos. ds.

18 Where was disease contracted Baltimore probably

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter Cash M. D.

8/6, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Govans Presbyterian cem.

Date of Burial 8/8 1927

20 UNDERTAKER Philip Herring

ADDRESS 2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

Gernet

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24558 | E 24558

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mun Hospital (Street) 4-30 (Ward)

2-FULL NAME Louis Gernet

(a) RESIDENCE NO. Longwood (Usual place of abode) Ind. Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 9th 1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Talbot Co Md.

PARENTS

10 NAME OF FATHER Jacob Gernet

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Gernet

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Jacob Hornberger

(Address) 1722 S Hanover St

15 Filed....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH was as follows:

Cor Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

Aug 6 1927 (signed) G C Radcliffe (Coroner) M. D.

(Address) 4316 Finney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Date of Burial Aug 8 1927

20 UNDERTAKER J. M. Cook ADDRESS 520 E North Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24559

CERTIFICATE OF DEATH

129 J

E 24559

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 507 Brunswick St. Ward) 20-12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alphonse Prevost

(a) RESIDENCE NO. 507 Brunswick St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S. if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louise Prevost

6 DATE OF BIRTH (month, day, and year): March 11 1858

7 AGE: Years 69 Months 4 Days 26

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mail

(b) General nature of industry, business, or establishment in which employed (or employer): Carrier

(c) Name of employer: U. S. Post Office

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Francis Prevost

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Constance Le Brun

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Louise Prevost

(Address) 507 Brunswick

15 Filed AUG 8 - 1927 19 C. HAMILTON FIELD Registrar

Per R P K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1927, to Aug 7, 1927, that I last saw h~~im~~ alive on Aug 7, 1927, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

1st Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

Arteriosclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Impression

(Signed) A. P. Hagerty, M. D.

. 19 (Address) 3316 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Date of Burial: Aug 9 1927

20 UNDERTAKER: William Cal ADDRESS 5026 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 ✓

E 24560

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Franco

(a) RESIDENCE NO. 1125 Porter St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2y yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): 5-29-27

7 AGE Years: 2 Months: 8 Days: 4 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: Marion Franco

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Italy

12 MAIDEN NAME OF MOTHER: Louise Allino

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Italy

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 8 - 1927, 19 C. BRANTON JONES, M. D. Registrar

Per BMK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 19 27, to Aug 7, 19 27, that I last saw him alive on Aug 7, 19 27, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Acute intestinal indigestion and pneumonia

(duration) 0 yrs. 0 mos. 5 da.

CONTRIBUTORY (Secondary) Emphysema

(duration) 6 yrs. 0 mos. 2 da.

18 Where was disease contracted

If not at place of death? At Home (1125 Porter St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Rathmann M. D.

19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent — Date of Burial: Aug 8 1927

20 UNDERTAKER: Thos. Cracknell Sons — ADDRESS: 1900 Eutaw

IMPORTANT: BLANKS MUST BE CAREFULLY FILLED, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24561

REGISTERED NO. E 24561

1-PLACE OF DEATH

City of BALTIMORE: (No. 219 N. Eden St. 5-9 Ward)

2-FULL NAME George Wainwright

(a) RESIDENCE NO. 219 N. Eden St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriet Wainwright

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE — Years: 59 — Months — Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Harriet Wainwright

(Address) 219 N. Eden St.

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5 1927

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1927, to Aug 5, 1927, that I last saw h[illegible] alive on Aug 5, 1927, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Larynx)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Gourley M. D.

8/7, 1927 (Address) 1429 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashury Cemetery — Date of Burial: Aug 9 1927

20 UNDERTAKER: Chris H. Johnson — ADDRESS: 46 N. Carolina

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24562

CERTIFICATE OF DEATH.

90 ✓ E 24562

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 642 S Mountford St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Gurecke

(a) RESIDENCE NO. 642 S Mountford St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE Marie Gurecke

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant John J. Gurecke Jr.

(Address) 642 S. Mountford

15 Filed ..... 19 .....

Per ..... Registrar

AUG 6 192 C. EXAMINER'S M

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 192 7

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) G. C. Yates M. D.

(Coroner)

6/29 (Address) 143 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial 8/9 1927

20 UNDERTAKER Mrs Galfsowsky ADDRESS 1618 Eastern

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24563

REGISTERED NO. E 24563

1-PLACE OF DEATH

City of BALTIMORE: (No. 33 Maple Ave. St., Hampden Road 9-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roland E English

(a) RESIDENCE NO. 210 E Augusta St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Genevieve A English

6 DATE OF BIRTH (month, day, and year) Jan 15th 1896

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Gaithersburg

(State or country) Maryland

PARENTS

10 NAME OF FATHER James T. English

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Gaithersburg Md

12 MAIDEN NAME OF MOTHER Eva Collins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Washington D.C.

14 Informant Mrs Genevieve A. English

(Address) 2104 Ausmith St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, aforesaid Inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Ac Indigestion

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) G C Hades

(Duration) ..... yrs. ..... mos. 1 ds.

Signed G C Hades M. D.

(Coroner)

Aug 6/27 (Address) 143 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — Date of Burial: Aug 10th 1927

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1100 Mount St

AUG 8 - 1927

C. HAMILTON JONES, M. D.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24564

CERTIFICATE OF DEATH.

2 E 24564

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1303 N. Carey ST. 15 13 WARD)

2-FULL NAME William Freeman

(a) RESIDENCE NO. 1303 N Carey ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Sept 5-1872

7 AGE: 54 Years 55 Months 11 Days / If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co

PARENTS

10 NAME OF FATHER: William Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Hester Freeman 1303 N Carey St.

15 Filed ..... 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 19 , 1926, to Aug 5 , 1927

that I last saw h alive on Aug 3 , 1927

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Wm. H. Wright, M. D.

Aug 6, 1927 (Address) 1209 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Aug 9 1927

20 UNDERTAKER: Ferguson & Toole — ADDRESS: 1165 Pa Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24565

40 E 24565

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 19-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Robinson

(a) RESIDENCE NO. 222 Bruce St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. 0 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 27. 1894

7 AGE — Years: 39 Months: 0 Days: 9

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Virginia

(State or country)

PARENTS

10 NAME OF FATHER: Paul Carr

11 BIRTHPLACE OF FATHER (City or town): Virginia

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Virginia

14 Informant: Mannie Leppard

(Address) 222 N. Bond st.

15 Filed ..... 19 .....

AUG 9 - 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 8-6-27

17 I HEREBY CERTIFY, That I attended deceased from 7-9-, 19 27 to 8-6-, 19 27

that I last saw h[illegible] alive on 8-6-, 19 27

and that death occurred, on the date stated above, at 4.00 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Bronchial Pneumonia) & Uremia, Extravasation Subarachnoid Well, Pneumonia, Scratches Ear Penis (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 7-9-27

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible] M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middletown Va — Date of Burial: Aug 9 1927

20 UNDERTAKER: Joseph A. Lichy. — ADDRESS 4899 Main

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 24566

E 24566

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 726 W Fairmount Ave St.) (Ward)

2-FULL NAME Clara Anderson

(a) RESIDENCE NO. 726 W Fairmount Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 8 mos. ds. 13 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 7

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov 23 1913

7 AGE — Years: 13 — Months: 8 — Days: 13 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: C Anderson

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Helen Reed

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Maryland

14 Informant: Helen Anderson

(Address): 726 W Fairmount Ave

15 Filed AUG 8 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon, and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above. (autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

I. B. Pul.

(duration) yrs. two mos. 5 wks

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Aug 5 27 (Signed) C Yates M. D.

(Coroner)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Lion — Date of Burial: Aug 8 1927

20 UNDERTAKER: Joseph A Lively — ADDRESS: 483 Argyle Street

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 24567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 E 24567

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Cottage Grove Beach

City of BALTIMORE: (No.) Aana Arundel Co., St. 18-26 (Ward)

2-FULL NAME Samuel Lests

(a) RESIDENCE NO. 1095 W. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6 DATE OF BIRTH (month, day, and year) Nov. 27th-1906

7 AGE	Years	Months	Days 10	IF LESS than 1 day.....hrs. or.....min.
	20	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Drug

(c) Name of employer Read Drug Co.

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Simon Lests

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie Berman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Simon Lests

(Address) 1095 W. Fayette St.,

15 Filed....., 19..... Registrar

AUG 9 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

Signed) (Coroner) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Hebrew Rosedale Cem.	8-8- 27

20 UNDERTAKER ADDRESS

, 1439 E. Balto. St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

20 5 2E 24568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-001 E 24568

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 16-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nella (Jones) Queen

(a) RESIDENCE NO. 1076 W - FAIRMONT St. Ward City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9/ mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-5-27

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	—	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Wm Jones

11 BIRTHPLACE OF FATHER (City or town) Md —
(State or country)

12 MAIDEN NAME OF MOTHER Isabel - Queen

13 BIRTHPLACE OF MOTHER (city or town) Md —
(State or country)

14 Informant Friends —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 8 - 1927, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1927

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1927, to Aug 6, 1927,
that I last saw h[illegible] alive on Aug - 6, 1927,
and that death occurred, on the date stated above, at 3 40 p. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Indigestion

(duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted
if not at place of death? 1076 W Fairmont Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial Aug 8th 1927

20 UNDERTAKER A. Jones — ADDRESS W. S. Gilmor et

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24569

154-003

154 E 24569

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel La Bar

(a) RESIDENCE NO. 2042 Gough St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13 - 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
		5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER John La Bar

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N Y

12 MAIDEN NAME OF MOTHER Dorothy Belz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSP.

15 Filed ..., 19.. C. HAMILTON JONES, M. D. Registrar

AUG 8 - 1927 Per RHJ

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 27, 19 27, to Aug 7, 19 27,

that I last saw h alive on Aug 7, 19 27,

and that death occurred, on the date stated above, at 3 7 m.

The CAUSE OF DEATH* was as follows:

Congenital Malformations of the Brain.

(duration) life yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Congenital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. R. Ehmen, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer Cemetery Aug 9 1927

20 UNDERTAKER Robt J Turner Sons ADDRESS N. Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24570

CERTIFICATE OF DEATH.

E 24570

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2089 N. Stricker St. Ward) 12-50

2-FULL NAME Philip Schlarb (Schlarb)

(a) RESIDENCE NO. 2831 Guilford Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Schlarb

6 DATE OF BIRTH (month, day, and year) Sept. 29. 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work mant. Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Clularby Schlarb

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Spahr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant (Address) Mrs. Dora Schlarb 2831 Guilford

15 Filed....., 19 Aug 9 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

~~Chronic~~ acute Indigestion

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. J. Riley M. D.

(Coroner)

Aug 6, 1927 (Address) 1659 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Aug. 9 1927

20 UNDERTAKER Henry Sander & Sons Inc. ADDRESS 1710 Fleet St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 9 - 1927

Spec.—12-9-25—A Co.—200 Pks.

E 24571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 24571

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 21-29 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances E Sink

(a) RESIDENCE NO. 1203 W Oxford St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Catherine Sink

6 DATE OF BIRTH (month, day, and year) June 6 - 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	69	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired machinist

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Geo Sink Do not know.

11 BIRTHPLACE OF FATHER (city or town) Pa.

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Lotts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs C. Ludig - Sister

(Address) 1203 W. Oxford St City

15 Filed AUG 8 1927, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6- 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2 1927, to Aug. 6, 1927,

that I last saw him alive on Aug 6, 1927,

and that death occurred, on the date stated above, at 3 50 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death! at home

Did an operation precede death! no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) A. J. Knapp, M. D.

8-6, 1927 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cathedral Cem. Date of Burial Aug 9 - 1927

20 UNDERTAKER John J Keenan & Son ADDRESS 901 Hollins St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

24572

E 24572

CERTIFICATE OF DEATH

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 944 S. Eutaw St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rena Inman

(a) RESIDENCE NO. 944 S. Eutaw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. – mos. – ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Foster Inman

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	42	–	–	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington

(State or country) N. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Delia Davis

13 BIRTHPLACE OF MOTHER (city or town) Wilmington

(State or country) N. Carolina

14 Informant Foster Inman

(Address) 944 S. Eutaw

15 Filed AUG 8 - 1927, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/20, 1927, to 8/5, 1927,

that I last saw her alive on 7/31, 1927,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

+ Chronic Nephritis

over 7 (duration) yrs. mos. – ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine + + +

(Signed) David Trimble, M. D.

8/6, 1927 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Aug 9 1927

Date of Burial

20 UNDERTAKER I. A. Bromwell Son

ADDRESS 1700 W. Baltimore St

I. A. BROMWELL, WITH CONTRACTING FIRM THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24573

CERTIFICATE OF DEATH.

38 E 24573

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hosp St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Crawford

(a) RESIDENCE NO. 1111 W. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Crawford

6 DATE OF BIRTH (month, day and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Crawford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Dora Gibson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) 1111 W Mulberry St alice crawford City

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Aug. 6 - 1927

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1927 to Aug. 6, 1927, that I last saw h[illegible] alive on Aug. 6, 1927, and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

General paralysis

? ~~Syphilis~~

(duration) ~~yrs.~~ yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic infection

(duration) Years yrs. mos. ds.

18 Where was disease contracted Unknown.

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. Pearlstein M. D.

Aug 8, 1927 (Address) Bolton City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt. Auburn Cemetery — Aug 9, 1927

20 UNDERTAKER — ADDRESS 322

Mr. Katie R. Williams N. Schroeder St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 10 1927

Spec.–7-17-26—A Co.—200 Bks.

E 24574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 24574

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 215 E Fort Ave St. 24-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Frances Michael

(a) RESIDENCE NO. 215 E Fort Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Frank Michael

6 DATE OF BIRTH (month, day, and year): Feb 15 1892

7 AGE: Years 35 Months 5 Days 21 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Frederick Co

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Chas A. Wolfe

11 BIRTHPLACE OF FATHER (City or town): Maryland

(State or country)

12 MAIDEN NAME OF MOTHER: Lillie Madary

13 BIRTHPLACE OF MOTHER (city or town): Maryland

(State or country)

14 Informant: Frank Michael

(Address) 215 E Fort Ave

15 Filed ....., 19.... C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 5 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1926, to Aug 5, 1927, that I last saw h[illegible] alive on Aug 5, 1927, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of April 1, 1926

Was there an autopsy? yes

What test confirmed diagnosis? Pathological findings

(Signed) Sidney H. Stratt, M. D.

8 5, 1927 (Address) 448 E Fort Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial 8/8/1927

20 UNDERTAKER: E. J. Fanning & Son — ADDRESS 1410 Battery Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-002 E 24575

E 24575 PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1017 Low St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geraline Mitchell

(a) RESIDENCE NO. 1017 Low St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, ~~Married, Widowed, or Divorced,~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: single

6 DATE OF BIRTH (month, day, and year): Not known.

7 AGE — Years: — Months: 5 — Days: — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: George Mitchell

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): md.

12 MAIDEN NAME OF MOTHER: Lena Brown

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: George Mitchell

(Address): 1017 Low St.

15 Filed ....., 19.....

AUG 8 - 1927 C. HAN... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 7 1927

17 I HEREBY CERTIFY, That I attended deceased from aug 6, 1927, to Aug 7, 1927, that I last saw h~~e~~r alive on Aug 6, 1927, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Richard I Eastridge M. D.

, 19 (Address) 1514 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury Cemetery — Date of Burial: aug 8 1927

20 UNDERTAKER: Lottie Gross — ADDRESS: 1455 McElderry

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24576 ✓ 113 E 24576

CERTIFICATE OF DEATH.

E 24576

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 S Exeter St. 3-5 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rudolph Pasquale

(a) RESIDENCE NO. 114 S Exeter St. Ward Hos Res

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) August 27 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		11.	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia

(State or country)

PARENTS

10 NAME OF FATHER Pete Pasquale

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Rosalia Cindria

13 BIRTHPLACE OF MOTHER (city or town) West Virginia

(State or country)

14 Informant Pete Pasquale

(Address) 114 S. Exeter St.

15 Filed....., 19..... Registrar

R R K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

Signed) ..... M. D.

(Coroner)

8/7/27 19 (Address) 114 S Exeter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Aug 8 1927.

20 UNDERTAKER Wendell J Hopped ADDRESS 300 S Eden

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24577 — 90 — E 24577

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 16-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Kirby

(a) RESIDENCE NO. 552. no. Arlington St. 20 Ward
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of mrs alice Kirby

6 DATE OF BIRTH (month, day, and year) Dec 15th 1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	71	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery man.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary County Md.

PARENTS

10 NAME OF FATHER Wm. Kirby

11 BIRTHPLACE OF FATHER (City or town) (State or country) St. Mary County Md.

12 MAIDEN NAME OF MOTHER Adah Bisco

13 BIRTHPLACE OF MOTHER (City or town) (State or country) St. Mary County Md.

14 Informant Wife — mollie Kirk
(Address) 2517 W Fayette

15 Filed ..... 19 ..... Registrar R.P.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-24-22, 19..., to Aug 7, 1927, that I last saw h.. alive on Aug 7, 1927, and that death occurred, on the date stated above, at 5.00 A. m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis
Hypertension + Arteriosclerosis
5 years (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Typical findings

(Signed) C. J. Williams Burns, M. D.
(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlew Cemetery. Date of Burial Aug 8th 1927

20 UNDERTAKER H.D. Wiepert ADDRESS 1850 W Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Bks.

E 24578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 24578

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 W. Biddle St. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Sampson.

(a) RESIDENCE No 426 W. Biddle ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Thomas Sampson.

6 DATE OF BIRTH (month, day, and year) 7-22-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	63	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Wilson Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Eliza Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Velma Saunders

(Address) 426 W. Biddle

15 Filed AUG 8 1927, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-4- 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-2-, 1927, to 8-4-, 1927, that I last saw h~ alive on 8-3-, 1927 and that death occurred, on the date stated above, at 10,15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis.

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Arteria sclerosis

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Gangler, M. D.

8-6; 1927 (Address) 611-N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Aug. 8 1927

20 UNDERTAKER David H. Hennessey

ADDRESS 1701 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-25—A Co.—200 Bks.

E 24579

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24579

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hayes

(a) RESIDENCE NO. 1202 Edmondson ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

Unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Hayes

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Illinois

PARENTS

10 NAME OF FATHER Nick Hayes

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Missouri

12 MAIDEN NAME OF MOTHER Julia Hayes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Missouri

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... C. H. Lawson Jones, M. D. Registrar

AUG 8 1927 By RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

August 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25, 19 27, to August 6, 19 27,

that I last saw him alive on August 6, 19 27,

and that death occurred, on the date stated above, at 3.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

Interculous Laryngitis Duration yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. E. Maddox, M. D.

8-6-19 27 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial 8/9/27 19

20 UNDERTAKER J. F. Dorsey ADDRESS 1925 Ellicott Drive

THIS IS A PERMANENT RECORD. Everything should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24580

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24580

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2813 Pennington Ave. 17-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jackson

(a) RESIDENCE NO. 2813 Pennington Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Aa	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
no	no	no	no	6 min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... no

(b) General nature of industry, business, or establishment in which employed (or employer) ..... no

(c) Name of employer ..... no

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Haley Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) SC

12 MAIDEN NAME OF MOTHER Martha Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Milwaukee Wis

14 Informant .....
(Address)

15 Filed ..... 19 .....

C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927, to Aug 6, 1927, that I last saw him alive on Aug 6, 1927, and that death occurred, on the date stated above, at 1:35 A M

The CAUSE OF DEATH* was as follows:

Drown or Immersion in A. Fluids following Birth

(duration) yrs. mos 5 m ds.

CONTRIBUTORY (Secondary) Weakness at Time of Birth (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) G. D. Hall, M. D.

, 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Cor.—1-12-23—M&T—100 Bks.

E 24581

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24581

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 317 N Fremont St. 4-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Kwon

(a) RESIDENCE NO. 317 N Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 30 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed , 192 Registrar

1598

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Coronary Occl

Exhaustion (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Signed , M. D. (Coroner)

July 31, 192 (Address) 336 Emory

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL , 192

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24582 ✓ 66 E 24582

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Druid Hill Ave ... St., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred Sutter

(a) RESIDENCE NO. 1601 Druid ... ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed ... 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cirrhosis (duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

(Coroner)

8/21, 192 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL ... DATE OF BURIAL ... 192

20 UNDERTAKER ... ADDRESS ...

UNIVERSITY OF MARYLAND

C. HAMPSON JONES, M. D.

8-1927 4509

matter should be stated EXACTLY. PHYSICIAN'S ... AGE, should be ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

E 24583

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1225 E Madison ST. 10-14 WARD) 159-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Burr

(a) RESIDENCE NO. 1225 E Madison ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant
(Address)

15
Filed , 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Lividity

(duration) yrs. mos 1 hr.

CONTRIBUTORY (Secondary) Evanosis

(duration) yrs. mos. 1 ds.

(Signed) G. C. Bladey, M. D.

(Coroner.)

8/27, 192 (Address) 436 Kenyon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

THIS SPACE TO BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIAN'S OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8 1927
1600

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24584 ✓ 113 E 24584

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1409 Etting St. 14-20 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lorraine D. Walker

(a) RESIDENCE NO. 1409 Ettinge St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 7 1926

7 AGE: Years — Months: 3 — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Va.

PARENTS

10 NAME OF FATHER Wm. Quisenberry

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy M. Walker

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va.

14 Informant Sarah Walker

(Address) 1409 Ettinge St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug. 5, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary) no other history

(duration) .....yrs. .....mos. .....ds.

(Signed) J. F. Hemmeter, M. D. (Coroner)

Aug 5 1927 (Address) 1802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 24585

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24585

CERTIFICATE OF DEATH

45

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 26-37 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny Miller

(a) RESIDENCE NO. Gerfman Hill Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of: Miles Miller

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: 50 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): md.

(State or country)

PARENTS

10 NAME OF FATHER: Perry Brown

11 BIRTHPLACE OF FATHER (City or town):

(State or country): md.

12 MAIDEN NAME OF MOTHER: Maria ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): ?

14 Informant: Husband

(Address): Herman Hill Rd

17 Filed AUG 8 - 1927, 19 C. HAMPSON Registrar

Per

1603

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-5 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-3, 1927, to 8-5, 1927, that I last saw her alive on 8-5, 1927, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hyperd + Suffection

(Signed) C. Andrews O'Bryde, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAU... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24586

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 24586

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [redacted] BALTIMORE CITY HOSPITALS 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Williams

(a) RESIDENCE NO. none St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 32 Years Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) N. Carolina
(State or country)

PARENTS

10 NAME OF FATHER Alex Williams

11 BIRTHPLACE OF FATHER (City or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Emily McDonald

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) NC.

14 Informant Pt
(Address)

15 Filed ..... 19 .....
Registrar

276 1927 1604 CRP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8–4 1927

17 I HEREBY CERTIFY, That I attended deceased from 8–2, 1927, to 8–4, 1927, that I last saw h[illegible] alive on 8–4, 1927, and that death occurred, on the date stated above, at 8.00 P.M.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted ?
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Holmes Boyd, M. D.

19 (Address)

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

C. HAMPSON

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 24587

REGISTERED NO.

E 24587

1-PLACE OF DEATH

City of BALTIMORE: (No. Edmondson Ave 4466 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelaide Lowe Jenkins

(a) RESIDENCE NO. Edmondson Ave Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 3 mos. 2 ds. How long in U. S. if of foreign birth? 82 yrs. 3 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: C. Austin Jenkins

6 DATE OF BIRTH (month, day, and year): May 5th 1845

7 AGE — Years: 82 Months: 3 Days: 2

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) Frederick Co (State or country) Md.

PARENTS

10 NAME OF FATHER Enoch Louis Lowe

11 BIRTHPLACE OF FATHER (City or town) Fredericktown (State or country) Md

12 MAIDEN NAME OF MOTHER Adelaide Victoria Lowe

13 BIRTHPLACE OF MOTHER (city or town) Bruceville (State or country) Md

14 Informant (Address) Miss Mary Adelaide Jenkins Edmondson Ave

15 Filed ..... 19 ..... Registrar

AUG 8 - 1927 Per RPH. C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to Aug 7, 1927, that I last saw h.. alive on Aug 7, 1927, and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

acute dilatation Heart disease

(duration) ..... yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Senile

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted Balto Md

If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Marshall D Hurst M. D.

19 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial Aug 9 1927

20 UNDERTAKER: Stewart & Mowenbo ADDRESS 108 N Howard

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 24588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 E 24588

(REGISTERED NO.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St. 12-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George B. Howser

(a) RESIDENCE NO. Homewood Apts. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? —yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Minnie D. Howser

6 DATE OF BIRTH (month, day, and year): Sept. 13, 1863

7 AGE 63 Years 10 Months 7 Days

IF LESS than 1 day —hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Business, wholesale hat

(b) General nature of Industry, business, or establishment in which employed (or employer): Owner & manager

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Gassaway Howser

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Cecelia Braunwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Deceased Homewood Apt.

15 [illegible] 19

AUG 8 1927 C. HUMPSON JONES, M.D. Registrar

Per RRS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1927, to Aug. 7, 1927, that I last saw him alive on Aug. 7, 1927, and that death occurred, on the date stated above, at 11 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (Coronary Thrombosis) (duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Acute nephritis (Uraemia) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sclerosis of coronary heart

(Signed) James Wilson Wendley, M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Druid Ridge Cem	Aug 10 1927
20 UNDERTAKER, John O Mitchell Son	ADDRESS 1910 Eutaw Place

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24589 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24589

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 7 S. Linwood ave ST., 1-V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Dugan

(a) RESIDENCE NO. 7 S. Linwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Dugan

6 DATE OF BIRTH (month, day, and year) Feb. 15 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	81	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Francis Dugan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Dugent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. E. Corsontine (Address) 7 S. Linwood ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Augs 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1- , 1927 , to Augs , 1927 .

That I last saw her alive on Augs 1- , 1927

and that death occurred, on the date stated above, at 8. p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 8 mos 8 ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Phy Ex-

What test confirmed diagnosis?

(Signed) W C Plater M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem 8/9/1927

20 UNDERTAKER J. A. Moran ADDRESS 306 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

G - 1927 C. LAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24590

CERTIFICATE OF DEATH.

31 E 24590

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST., 1951 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James C Herbert

(a) RESIDENCE NO. Clayton, Delaware ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12 - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S. Navy Yard

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ....., 19.... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1927

17

I HEREBY CERTIFY, That I attended deceased from June 25, 1926, to Aug 7, 1927.

that I last saw h[illegible] alive on Aug 7, 1927.

and that death occurred, on the date stated above, at 5-10 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculous peritonitis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical findings & Laboratory test

(Signed) Lew Benton, M. D.
Asst Surgeon U.S.P.H.S.

8-7, 1927 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's, Hampden	Aug. 9, 1927
20 UNDERTAKER	**ADDRESS**
C. Leroy Stiffler	125 E. North ave.

Aug 9 - 1927

Before signing be careful that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 24591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 24591

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 N. Fulton ave ST. 16-22 WARD)

2-FULL NAME Harry Lassington Kimmel

(a) RESIDENCE. No. 922 N. Fulton ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

55 If married, widowed or divorced
HUSBAND of
(or) WIFE of Cora M. Kimmel

6 DATE OF BIRTH (month, day, and year) July 7. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Grafton
(State or country) W. Va

PARENTS

10 NAME OF FATHER Simon P. Kimmel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER H. Lassington

13 BIRTHPLACE OF MOTHER (city or town) Winchester
(State or country) Va

14 Informant Grace Kimmel
(Address) 922 N. Fulton

15 Filed AUG 8 - 1927, 19 HAMPSON JONES, M. D. Registrar
By HCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1927, to date of death, that I last saw him alive on Aug 8, 1927, and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

Duration was due to Interstitial Nephritis of Long Standing

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Amebic Dysentery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Anthony Lee Davis, M. D.

, 19 (Address) 922 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grafton West Va	Aug 9 19 27

20 UNDERTAKER Jos Joerdens Son ADDRESS 2178 Pa. Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26 —A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24592

38 E 24592

REGISTERED NO.

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. ... St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Collins

(a) RESIDENCE (No. 1315 Orleans St. St. ... Ward ...)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Mary Collins

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE 55 Years Months Days IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Pocomoke City

(State or country) md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country) md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) md.

(State or country)

14 Informant Patient

(Address) ...

15 Filed AUG 9 - 1927 19 ... Registrar

E. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1925, to Aug 5, 1927, that I last saw him alive on Aug 5, 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Left Hemiplegia, old (Embolic)

Cerebral Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis (?)

(?) (duration) ... yrs. mos. ds.

18 Where was disease contracted ?

if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? yes

What test confirmed diagnosis? Wasserman tests

(Signed) C. Holmes Boyd, M. D.

19 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial 8—10—1927

20 UNDERTAKER: Mrs Chas L. Bailey — ADDRESS 1421 Jefferson St

---

To be carefully filled in, with the CAUSE OF DEATH stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Alexander Clark -

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24593

38 ✓

CERTIFICATE OF DEATH

E 24593

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clark, Alexander

(a) RESIDENCE NO. 571 Walnut St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Hester Clark

6 DATE OF BIRTH (month, day, and year) 1884 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) shipping coal

(c) Name of employer unknown

9 BIRTHPLACE (city or town)

(State or country) Anne Arundel Co., Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not known

14 Informant Hester Clark

(Address) 571 Walnut Ave

15 Filed AUG 9 1927 19 H. M. JONES, M. D. Registrar

By R. H. L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-5-27

17 I HEREBY CERTIFY, That I attended deceased from 8-4-27, 19..., to 8-5-27, 19...,

that I last saw him alive on 8-4-27, 19...,

and that death occurred, on the date stated above, at 8:10 a m.

The CAUSE OF DEATH* was as follows:

Cardio vascular renal disease

a) Arteriosclerosis - Probably

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) acute heart failure

(duration) yrs. mos. 1/2 hour

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) F. P. Lusby, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn — Date of Burial aug 9 - 19 27

20 UNDERTAKER Howard Easton — ADDRESS 912 Eo -

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24594

CERTIFICATE OF DEATH

49 E 24594

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M Hampton

(a) RESIDENCE NO. 631 W Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Hampton

6 DATE OF BIRTH (month, day, and year) 4-18-1900

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	27	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) S C

PARENTS

10 NAME OF FATHER Mack Hampton

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Florida

12 MAIDEN NAME OF MOTHER Susie Christy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S. C

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to Aug 6, 1927

that I last saw him alive on Aug 6, 1927

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Hypernephroma

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Norma Rogers, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn	Aug 9 1927

20 UNDERTAKER Daniel Easton ADDRESS 916

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24595

CERTIFICATE OF DEATH.

188-003

E 24595

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE (No. Vol of Am Hosp. St. 9-46 Ward)

2-FULL NAME John Thomas Conniff

(a) RESIDENCE NO. 606 Montpelier St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M Conniff

6 DATE OF BIRTH (month, day, and year) 9 19 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER John T. Conniff

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER L Hayden

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Balto Md

14 Informant Frank A Kriener

(Address) 1106 Hillmon St

15 Filed _____ 19 _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Acc.

Fracture of Skull

(Duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ____ yrs. ____ mos. ____ ds.

8/7, 19 (Signed) G E Pates M. D.

(Coroner)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monte Marie Cemetery Date of Burial 8/10 1927

20 UNDERTAKER George J. Ruth ADDRESS 1355 Hanford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24596

CERTIFICATE OF DEATH

129 E 24596

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2029 Harlem Ave St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Martha Ellen Cuddy.

(a) RESIDENCE NO. 2029 Harlem Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ✓ mos. ✓ ds. How long in U. S. if of foreign birth? ~~yrs.~~ ~~mos.~~ ~~ds.~~

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. Cuddy

6 DATE OF BIRTH (month, day, and year): Oct 20 - 1850

7 AGE: Years 76 Months 9 Days 17 IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Texas

(State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: Robt McCleland

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER: Eve Barton

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Black Horse Harford Co Md

14 Informant: Frank E. Cuddy

(Address) 2029 Harlem Ave

15 Filed AUG 9 - 1927 HAMPTON JONES, M. D. Registrar

Per RAH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 6 - 1927

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1927, to Aug 6, 1927, that I last saw h. er alive on Aug 4, 1927, and that death occurred, on the date stated above, at 8.15 p. m.

The CAUSE OF DEATH* was as follows:

Hepatitis Chronic

(duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ✓ yrs. 6 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) George E. Shannon, M. D.

Aug 6. 1927 (Address) 705 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Aug 9 1927

20 UNDERTAKER: Wm. J. McKeon & Sons ADDRESS: Roter & Fa

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1660 E 24597

1-PLACE OF DEATH Union Memorial Hosp. REGISTERED NO. 13-52

City of BALTIMORE: (No. 33d & Calvert Sts St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Otho Causey

(a) RESIDENCE NO. 606 W 36th St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 26 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 19 1927

7 AGE — Years: 0 Months: 6 Days: 26 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Edward E. Causey

11 BIRTHPLACE OF FATHER (City or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Katherine Cochran

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mother

(Address)

15 Filed , 19 Registrar

AUG 9 - 1927 C. HAMPSON JONES, M. D. R.R.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1921, to Aug 9, 1927, that I last saw h[im] alive on Aug 9, 1927, and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Wallace L. Swartzbaugh M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial: Aug 9 1927

20 UNDERTAKER: Mr Mrs J. W. Teufel & Son — ADDRESS: 801 W Fayette

Spec.—1-12-23—M&T—50¢ Bks.

White 1106 N Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24598
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

113 E 24598
REGISTERED NO.

CITY OF BALTIMORE: (No. 1202 N. Rutland St. Apt 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen May Felker

(a) RESIDENCE No. 1202 N. Rutland ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12-1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Felker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Lottie Ashley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant John Felker
(Address) 1202 N. Rutland Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927, to Aug 7, 1927, that I last saw h.er alive on Aug 6, 1927 and that death occurred, on the date stated above, at 7:15 A m

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Diarrhoea (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White M. D.

, 19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fontaine Cemetery — DATE OF BURIAL Aug 9 1927

20 UNDERTAKER William Cook — ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 9 1927 C BAMPTON M.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24599

CERTIFICATE OF DEATH

11-001

E 24599

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1307 Jones ✓ St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Virginia Miller

(a) RESIDENCE NO. 1307 Jones ✓ St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 10 mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert T. Miller

6 DATE OF BIRTH (month, day, and year): Sept 29 1898

7 AGE: Years 28 Months 10 Days 9

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Payne

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Robert Thomas Miller

(Address): 1307 Jones ✓

15 Filed AUG 9 - 1927, 19 ..... Registrar

Per RMK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 8 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Aug 8, 1927

that I last saw h[illegible] alive on Aug 2, 1927

and that death occurred, on the date stated above, at 3 [illegible] m.

The CAUSE OF DEATH* was as follows:

From Nephritis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? ..... What test confirmed diagnosis?

(Signed) Mitchell Davis M. D.

, 19 (Address) 1727 Madison Ave

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

Date of Burial: Aug 10 1927

20 UNDERTAKER: Jos Joerdens & Son

ADDRESS: 2178 E. [illegible]

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24600 — 29 — E 24600

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 27-47 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elloyd Mayo

(a) RESIDENCE NO. 903 Arlington Ave. St. Govanstown Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of aug 4

6 DATE OF BIRTH (month, day, and year) 1918

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	nine		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Govanstown

(State or country)

PARENTS

10 NAME OF FATHER Elloyd Mayo

11 BIRTHPLACE OF FATHER (City or town) born in Wales

(State or country)

12 MAIDEN NAME OF MOTHER Lara Henry

13 BIRTHPLACE OF MOTHER (city or town) born in Balt-City

(State or country)

14 Informant Lara Henry

(Address) 903 Arlington Ave. Govanstown

15 Filed AUG 9 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from aug 6, 1927, to aug 7, 1927,

that I last saw him alive on aug 7, 1927,

and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

accidental laceration of the carotid of left leg

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) I stance

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? 903 arlington ave. Govanstown

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. S. Anderson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn Tenn	Aug 10. 1927
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1225 Ashland Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24601

31 ✓ E 24601

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Irvine (Irwin)

(a) RESIDENCE NO. 1933 E. Biddle st. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1906

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Lynchburg

(State or country) Virginia

PARENTS

10 NAME OF FATHER Nick Irvine

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Matilda Watts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... Registrar

AUG – 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

August 6, 1927

17

I HEREBY CERTIFY, That I attended deceased from July 25, 19 27, to August 6, 19 27,

that I last saw him alive on August 6, 19 27,

and that death occurred, on the date stated above, at 3.20 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Probably the Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) L E Mud Lum, M. D.

8-6- . 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg Va

Date of Burial Aug 8, 1927

20 UNDERTAKER Mrs. K. A. Elliott

ADDRESS 13-5 Ashland Av.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

72 E 24602

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Russ

(a) RESIDENCE NO. 730 E. Pratt St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE 57 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Meat cutter

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Lithuania

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Lithuania

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant Herman Russ

(Address) 900 So 2nd St

15 Filed AUG 9 - 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927, to Aug 7, 1927, that I last saw him alive on Aug 7, 1927, and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

Syphilis of Central nervous system

Tabes Dorsalis

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Subjective & Objective

(Signed) C. Holmes Bond M. D.

, 19 (Address)

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or if Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. H. Schwartz Cem

Date of Burial Aug 9 1927

20 UNDERTAKER John Lucerick

ADDRESS 200 E Oliver

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24603

E 24603

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSP. St. 15-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Brent

(a) RESIDENCE NO. 1628 Westwood Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Venetta Brent

6 DATE OF BIRTH (month, day, and year) 4-18-78

7 AGE	Years	Months	Days
	49	3	20

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt Md

(State or country)

PARENTS

10 NAME OF FATHER George Brent

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1927, to Aug 7, 1927, that I last saw him alive on Aug 7, 1927, and that death occurred, on the date stated above, at 9-31 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Oesophagus

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death? 1628 Westwood Ave.

Did an operation precede death? yes Date of Aug 1927

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Henry A Colmers M. D.

8-8, 1927 (Address) Johns Hopkins Hosp Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

Date of Burial Aug 1 1927

20 UNDERTAKER David W. Chase & Son

ADDRESS Woodlawn

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 24604

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 N. Gilmor ST. 16-22 WARD)

2-FULL NAME Lucy N. Hughes

(a) RESIDENCE NO. 1105 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced, (write the word)
F	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	46	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Jacob Traynham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Willis Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Albert Hughes

(Address) 1105 N. Gilmor

15 Filed AUG 9 - 1927 THAWLEY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1927 to Aug 8, 1927, that I last saw her alive on Aug 8 1927 and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death: no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Postive

(Signed) Dr Gilliam Kennard, M. D.

8-8, 1927 (Address) 908 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Va — DATE OF BURIAL Aug 10 1927

20 UNDERTAKER Wm H. Edmondson — ADDRESS Westminster Md

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 24605 — REGISTERED NO. E 24605

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto city Hospitals St., 4th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pete Patricia

(a) RESIDENCE NO. 1606 Alice Ann St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Brown

6 DATE OF BIRTH (month, day, and year) 1867 ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Petricia

11 BIRTHPLACE OF FATHER (City or town) (State or country) Serbia

12 MAIDEN NAME OF MOTHER Agnes Stieffa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Serbia

14 Informant (Address) Hospital Records

15 Filed AUG 9 - 1927, 19 Per RMC, Registrar

C. Addison Jones, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927 to Aug 7, 1927

that I last saw h[illegible] alive on Aug 7, 1927

and that death occurred, on the date stated above, at 10.4[illegible] A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. E. Madden M. D.

8/7 1927 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Druid Hill Cem.	Aug 10 1927
20 UNDERTAKER M. F. Jackowski	ADDRESS 705 S. Ann

tion should be carefully supplied. AGE should be stated-EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24606

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24606

16 y 403

CERTIFICATE OF DEATH.

REGISTERED NO. 19-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 437 S. Parrish ST. (WARD)

2-FULL NAME Lillian J. Marfield

(a) RESIDENCE NO. 437 S. Parrish ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Lawrence R. Marfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Christina Holder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Lawrence Marfield (Address) 437 S. Parrish St

15 Filed AUG 9 - 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6, 19 27

17

I HEREBY CERTIFY, That I attended deceased from August 5, 19 27 to August 19 27

that I last saw her alive on 19

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Ilio Colitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw Kaufman, M. D.

19 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Aug 9 1927

20 UNDERTAKER: Harry H. Weitzel — ADDRESS: 1516 W Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24607

E 24607

CERTIFICATE OF DEATH

90

12-50

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2625 N. Calvert Street, St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Renneburg

(a) RESIDENCE NO. 2626 N. Calvert Street St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSI ANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Renneburg

6 DATE OF BIRTH (month, day, and year) June-24-1844

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	83	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired D.

(b) General nature of industry, business, or establishment in which employed (or employer) ""

(c) Name of employer ""

9 BIRTHPLACE (city or town) ? ?

(State or country) Germany

PARENTS

10 NAME OF FATHER Christian Renneburg

11 BIRTHPLACE OF FATHER (City or town) ? ?

(State or country) Germany

12 MAIDEN NAME OF MOTHER ?????? ????

13 BIRTHPLACE OF MOTHER (city or town) ? ?

(State or country) Germany

14 Informant Miss. Mary Renneburg (daughter)

(Address) 2625 N. Calvert Street.

15 Filed AUG 9 1927 C. HAMPSON JONES, M. D. Registrar

By H.A.W. Stewart & Warner Co. 108 W. North Ave.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6 1927 to Aug 8 1927

that I last saw h[illegible] alive on Aug 7 1927

and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Arteriosclerosis

(duration) 2 months

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 months

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

. 19 (Address) 1439 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Druid Ridge Cemetery — Aug-11-27 19

20 UNDERTAKER — ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 24608 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24608

CERTIFICATE OF DEATH. 662

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Pasuk

(a) RESIDENCE NO. 2302 Boston street ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of David Pasuk.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
26				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barmaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Martin Hudak.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant David Pasuk.

(Address) 2302 Boston st

Filed AUG 9 - 1927 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7/27 19

17 I HEREBY CERTIFY, That I attended deceased from 7/28/27, 19, to 8/7/27, 19, that I last saw her alive on 8/7/27, 19, and that death occurred, on the date stated above, at 10:25 P. m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Laurence Fahey, M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, St Hamilton Cem. DATE OF BURIAL Aug 11 1927

20 UNDERTAKER H. A. Weber ADDRESS George A. Weber 2206 Boston st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24609

E 24609

CERTIFICATE OF DEATH.

21-29

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 905 Ryan (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Magness,

(a) RESIDENCE NO. 905 Ryan St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal.	Wht.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Magness.

6 DATE OF BIRTH (month, day, and year) June 14, 1878.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer,

(b) General nature of industry, business, or establishment in which employed (or employer) Produce Dealer.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Magness.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Katherine Magness.

(Address) 905 Ryan St.

15 Filed AUG 5 - 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8. 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1927, to Aug. 8, 1927, that I last saw him alive on Aug 8, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Urin Analysis etc.

(Signed) Chas. Norton, M. D.

8/9/27 (Address) 888 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Aug 10 1927

20 UNDERTAKER John J. Bowan & Son

ADDRESS 901 Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 24610

REGISTERED NO. 26141

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Onfri Kopcieski

(a) RESIDENCE NO. 2022 Fairview ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Jos. Kopcieski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Paulina Kopcieski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Hospital Records

(Address)

15 Filed AUG 9 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 26, 19 27 to August 8 19 27

that I last saw him alive on August 8, 19 27

and that death occurred, on the date stated above, at 8.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. E. Madden, M. D.

(Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Aug 11 Date of Burial 1927

20 UNDERTAKER J. W. Ozazewski ADDRESS 1930 Eastern

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 24611

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE (No. 368 Wilbud. St. 3-4 Ward)

2-FULL NAME Pauline Zakrzczymski

(a) RESIDENCE NO. 368 S-Wilbud St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year): unknown 1894

7 AGE: Years 33 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Frank Zakrzczymski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

Informant Frank Zakrzczymski
(Address) 368 S. Wilbud

15 Filed Aug 9 1927 Registrar R M K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1927

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

Aug 9 1927 (Signed) G E Yates M. D.

8/27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Date of Burial Aug 10 1927

20 UNDERTAKER: F W Chazewski ADDRESS 1730 Eastern

If the following information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Mary Knox

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24612

CERTIFICATE OF DEATH.

124 E 24612

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 237 Forrest St. 5-8 Ward)

2-FULL NAME Mary Knox

(a) RESIDENCE NO. 237 Forrest St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Col.	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed ....., 19 .....

1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Tuesday (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Duty Anemia Hemorrhage of Uterus

Cause of Fibroid tumor

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Aug 4 (Signed) [illegible] M. D.
(Coroner)

, 192 9 (Address) 1039 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 24613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 24613

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2236 Lombard St., 2-5 Ward)

2-FULL NAME Kate Blunt

(a) RESIDENCE NO. 2236 Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Chronic (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. C. Yates M. D.

(Coroner)

7/27 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

tion should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

1669

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24614

E 24614

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 16-31

BALTIMORE CITY HOSP 16-31 31

City of BALTIMORE: (No. ..... St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jennie Monti

(a) RESIDENCE NO. Pt. in Insane dept. Balt. City Hosp St. ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth 7yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White Italian

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emilio Monti

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 40 Months: — Days: — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town): Italy

(State or country) Unknown

PARENTS

10 NAME OF FATHER: Italy

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Italy

(State or country) Unknown

14 Informant: Joe Monti

(Address) 732 Decatur

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 16 1927 to Aug 4 1927

that I last saw her alive on Aug 4 1927

and that death occurred, on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....

(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? no + X-Ray

What test confirmed diagnosis? Laboratory — Bacilli

(Signed) C. Hampson Jones, M. D.

(Address) ..... 19 .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: 8/10 1927

20 UNDERTAKER: J. H. McGowan

ADDRESS: 1318 Druid Hill Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 E 24615

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE, No. New Hospital St. 15-56 (Ward)

2-FULL NAME Mamie E. Cochrane

(a) RESIDENCE NO. 4140 Pimlico St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cockran Catherine

6 DATE OF BIRTH (month, day, and year) Nov. 9- 1891

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
35	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barroom owner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer do

9 BIRTHPLACE (city or town)

(State or country) Kent Co. Md

PARENTS

10 NAME OF FATHER J. P. Cockran

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Del.

12 MAIDEN NAME OF MOTHER Mollie McGrath

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Frank Cockran

(Address) Govans Md

15 Filed ..... 19..... Registrar

1927 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Alcoholism

Cardiac Degeneration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

8/9/27 (Signed) H. C. Grady M. D.

8/9/27 (Address) 44 Hot Spring (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmell Date of Burial 8/10/27

20 UNDERTAKER Joseph Ahrens ADDRESS 221 Bway

(Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24616

CERTIFICATE OF DEATH.

E 24616

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp't St. _____ Ward)

2-FULL NAME Dudley F. Bryan

(a) RESIDENCE NO. Huntington W Va. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driving Car

(b) General nature of industry, business, or establishment in which employed (or employer) Elevator

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Ohio

PARENTS

10 NAME OF FATHER John Bryan

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Emma Hood

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Ohio

14 Informant Dr C. H. Bryan

(Address) Bradenton Fla

15 Filed ..... 19 ..... Registrar

1927 C. HANSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Razor Wound

Throat Suicide

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

(Signed) C. C. Yates M. D.
(Coroner)

19 (Address) 143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Huntington W Va Aug 9 1927

20 UNDERTAKER John O Mitchell ADDRESS 1900 Eutaw

Physician should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

E 24617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24617

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Clarkson ST. 23-32 WARD) 74-09

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Schmalzemeyer

(a) RESIDENCE No. 1630 Clarkson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emil Schmalzemeyer

6 DATE OF BIRTH (month, day, and year) Oct. 0th 1866

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
60	9	28 9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germy

PARENTS

10 NAME OF FATHER George Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Katharine Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Charles Schmalzemeyer (Address) 1630 Clarkson St

15 Filed Aug 9 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 2, 1927, to Aug 8, 1927.

that I last saw h alive on Aug 8, 1927,

and that death occurred, on the date stated above, at 11-30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Alex. Campbell M. D.

Aug 10 1927 (Address) 1644 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Aug 11 1927

20 UNDERTAKER E Schlosman & Son

ADDRESS 1137 Lanvale

Cor.—t-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24618 E 24618

CERTIFICATE OF DEATH.

REGISTERED No. 66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Pine Lane ST. 3-H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 8.)

2-FULL NAME Mrs. Carter

(a) RESIDENCE No. ~~1606 Pine Lane~~ ST. WARD 237 Herring Court.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	unknown	unknown	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer unknown.

9 BIRTHPLACE (city or town) (State or country) Montgomery Co Md.

PARENTS

10 NAME OF FATHER James Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Shaw.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co Md.

14 Informant Mrs. Anna Carter. (Address) 237 Herring Court.

15 Filed , 192 Registrar

C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

~~Tuberculosis~~ Alcoholism

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) M.D. (Coroner) 46 Years M. D.

Aug 27, 192 (Address) 2 Conway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westwood Cem	Aug 7, 1927

20 UNDERTAKER Wendell J. Lippel ADDRESS 300 N Eden St

TION is very important See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 24619

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 E 24619

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 249 Schenley Road ST., 27th WARD)

2-FULL NAME Harry R. Houser

(a) RESIDENCE No. 249 Schenley Road ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella A. Houser

6 DATE OF BIRTH (month, day, and year) May 10-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Concrete Block Mfgr.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1½ years.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER John J. Houser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Lovell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Ella A. Houser
(Address) 249 Schenley Road

15 Filed ..... 19..... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8. 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 8 1927 to Aug 8 1927

that I last saw him alive on Aug. 7 1927

and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.
General Arterio Sclerosis.

(duration) 2 yrs 4 mos t ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. 4 mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of urine

(Signed) M. Gibson Porter, M. D.

8/9. 1927 (Address) 422 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug. 10 1927

20 UNDERTAKER Horace F. Burgee ADDRESS 3031 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24620

CERTIFICATE OF DEATH.

84 E 24620

1-PLACE OF DEATH C

City of BALTIMORE: (No. 735 Mt Cabr Ave St., 27-48 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Dolores Bowers.

(a) RESIDENCE NO. 735 Mt Cabr Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 5-1925

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Harry A. Bowers

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Ethel L. Morris

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Maryland

14 Informant: Harry A. Bowers
(Address): 735 Mt Cabr Ave

15 Filed....., 19..... M. D.....
Registrar

DEC 9 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 8 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Convulsions (Central)

(duration) ..... yrs. 7 mos. 2 hrs.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ..... yrs. ..... mos. 1 hr.

(Signed) G E Yates M. D.
(Coroner)

Aug 9 1927 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. Date of Burial: Aug. 10 192 7

20 UNDERTAKER: Horace H. Burgee ADDRESS: 363 Fallsld

If DEATH occurred in a hospital or institution, the NAME and LOCATION should be stated EXACTLY. The questions should be properly answered and the certificate properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 24621

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3010 Hudson St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E Adams

(a) RESIDENCE NO. 3010 Hudson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 6-1927

7 AGE: Years | Months | Days 3 | IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John E Adams

11 BIRTHPLACE OF FATHER (City or town): Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Mary H Albert

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: John E Adams

(Address) 3110 Hudson St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9-1927

17 I HEREBY CERTIFY, That I attended deceased from 8/8, 1927, to 8/9, 1927, that I last saw him alive on 8/9, 19..., and that death occurred, on the date stated above, at 8 10 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Asthma & Heart failure

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N V Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & appearance

(Signed) Jay A Pullen, M. D.

8/9. 1927 (Address) 1623 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cem — Date of Burial: Aug 10 1927

20 UNDERTAKER: John Ulrich — ADDRESS: 2301 Eden

AUG 10 1927

REGISTRAR

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Entries should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24622 E 24622

91-002

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4200 Walnut Ave. St. 28-66 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise H. Weyler

(a) RESIDENCE NO. 4200 Walnut Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Weyler

6 DATE OF BIRTH (month, day, and year) June 1st., 1847

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	80	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Hillen

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary M. Franke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Koehler(niece)

(Address) 4200 Walnut Ave.

15 Filed ..... 19 ..... Registrar

1927 ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6th., 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 19 27, to Aug 6, 19 27,

that I last saw h[illegible] alive on Aug 6, 19 27,

and that death occurred, on the date stated above, at 11.30 PM

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Cardiac hypertrophy

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical course

(Signed) Jos H Zierler M. D.

Aug 9 1927 (Address) 1122 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Aug. 10 1927

20 UNDERTAKER Margaret L. Flynn ADDRESS 1422 Eight

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24623

CERTIFICATE OF DEATH

E 24623

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) University Hospital (Street) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Peppler

(a) RESIDENCE NO. 2007 W. Balto. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed or divorced (or) WIFE of Edward H. Peppler

6 DATE OF BIRTH (month, day, and year) April 9, 1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Franklyn Livingston

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Munnick

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

14 Informant Edward H. Peppler

(Address) 2117 W. Balto. Md.

15 Filed ..... 19 ..... Registrar

1927 Per .....

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/5, 1927, to 8/7, 1927

that I last saw h alive on 8/7, 1927

and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Lusby, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. — Date of Burial aug 11 1927

20 UNDERTAKER Margaret G. Flynn — ADDRESS 1722 Light

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24624

CERTIFICATE OF DEATH.

E 24624

1-PLACE OF DEATH

City of BALTIMORE: (No. J. H. Hospital St. 1-3 Ward)

2-FULL NAME Heinsetta Doemling

(a) RESIDENCE NO. 201½ S Madeira St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Doemling

6 DATE OF BIRTH (month, day, and year): Dec 6 1891

7 AGE — Years: 35 Months: 8 Days: 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baltimore

PARENTS

10 NAME OF FATHER: Herman Rahsen

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Holland

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Baltimore

14 Informant

(Address): 201½ S Madeira

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Aug 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Post Partum Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) H. C. Stadler M. D.

(Coroner)

9/27 (Address) 1436 Bway

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial: Aug 11 1927

20 UNDERTAKER: Wendell Dippel & Son ADDRESS: 37 S Am

Cause should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

265-472 E 24625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 84 E 24625

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lenard Lesenen

(a) RESIDENCE NO. 65-7 Willis Ave St. Ward Brooklyn N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May-10-1910

7 AGE — Years: 17 Months: 7 Days: 29

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Brooklyn

(State or country): N.Y.

PARENTS

10 NAME OF FATHER: Joseph Lesenen

11 BIRTHPLACE OF FATHER (City or town): Russia
(State or country)

12 MAIDEN NAME OF MOTHER: Bella

13 BIRTHPLACE OF MOTHER (city or town): Russia
(State or country)

14 Informant: Records -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 10 1927, 19.... (CHANNING JONES, M.D.) Registrar

Per ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1927, to Aug 9, 1927, that I last saw him alive on Aug 9, 1927, and that death occurred, on the date stated above, at 1 10 P. M.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Midbrain
Glioma

Symptoms (duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Brooklyn, N.Y.

Did an operation precede death? Yes Date of Aug. 9, 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Hart, M. D.

Aug. 9. 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New York, N?Y?	Aug. 9. 1927
20 UNDERTAKER	ADDRESS
Hughes & Jones Inc.	434 N. Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Leonard Lesenen Burial

Armand Du Breuil

Spec.–7-17-26—A Co.—200 Bks.

E 24626

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 24626

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3327 Edmondson St., 8-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Armand DuBreuil

(a) RESIDENCE NO. 3327 Edmondson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth ~~58~~ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	~~5 Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Late Laura DuBreuil

6 DATE OF BIRTH (month, day, and year) March 30 / 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	72.	4	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) French West Indies

PARENTS

10 NAME OF FATHER Armad Du Breuil

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Martinique

12 MAIDEN NAME OF MOTHER Laura Brun

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Clara A. DuBreuil

(Address) 3327 Edmondson Ave.

15 Filed ..... 19 .....

AUG 10 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6- 1927.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1926 to recently 19..., that I last saw him alive on a few months ago, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows: Chronic cardiac valvular disease with cardiac dilatation. (Death was sudden while getting up from dinner table.) (duration) Several years ds.

CONTRIBUTORY (Secondary) X

(duration) X yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Cardiac auscultation.

(Signed) O. H. Hoffman, M. D.

8-8-1927 (Address) 2500 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery. Date of Burial: Aug 10 1927

20 UNDERTAKER: Geo. J. Roth ADDRESS: 1735 Harford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 24627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 24627

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No.) St. 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeff Coles

(a) RESIDENCE No. 524 80 2nd St. St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Unknown 1875

7 AGE 52 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Abraham Cole

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Susan ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mary Redd

(Address) 521 E. 2nd St.

15 Filed AUG 10 1927, 19 [illegible]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 6 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-19, 1926, to 8-6, 1927, that I last saw him alive on 8-6, 1927, and that death occurred, on the date stated above, at 1150 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Subjective & objectively

(Signed) J. C. Salmon Boyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — Date of Burial: Aug 10, 1927

20 UNDERTAKER: Wm. H. Elliott — ADDRESS: 122 W. Saratoga

AUG 10 1927 C. HAMPSON JONES, M. D.

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24628 + 44 E 24628

E 24628

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. University Hosp St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hall, Richard

(a) RESIDENCE NO. Hanover, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Hall

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE — Years: 39 — Months: unknown — Days: unknown — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer): farmer

(c) Name of employer: unknown

9 BIRTHPLACE (city or town): unknown

(State or country): Md.

PARENTS

10 NAME OF FATHER: Richard Hall

11 BIRTHPLACE OF FATHER (City or town): unknown

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Laura Parker

13 BIRTHPLACE OF MOTHER (city or town): unknown

(State or country): Md.

14 Informant: Hosp. record

(Address)

15 Filed AUG 10 1927 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 8-7-27

17 I HEREBY CERTIFY, That I attended deceased from 8-3-27, 19..., to 8-7-27, 19..., that I last saw ~~living~~ alive on 8-7-27, 19..., and that death occurred, on the date stated above, at 8:10 a.m.

The CAUSE OF DEATH* was as follows:

Malignancy of liver

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary): cardiac dilatation 15 min.

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) L. F. Lusby, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn Cem — Date of Burial: Aug 10 27

20 UNDERTAKER: Samuel Brinsley — ADDRESS: Middle

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 24629

E 24629

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1032 N. Stockton ST. 16-23 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Garrison

(a) RESIDENCE NO. 1032 N. Stockton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of John Garrison

6 DATE OF BIRTH (month, day, and year) Jan. 25-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Hand Laundry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Willard Cortez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Jane Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant (Address) Pearl Lane (mother) 1032 N. Stockton St.

15 Filed AUG 10 1927, 19 ... E. H. KELLY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7- 1927

17 I HEREBY CERTIFY, That I attended deceased from June 20- 1927 to Aug. 7- 1927.

that I last saw her alive on Aug 6- 1927.

and that death occurred, on the date stated above, at 7-30 A m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. Bacilli Inoculated.

(Signed) Paul Brown, M. D.

8-7-1927 (Address) 1837 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 8-10-1927

20 UNDERTAKER Virgie A. Brodie

ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24630

CERTIFICATE OF DEATH.

5001
M E 24630

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 S. Payson ST. 20-28 WARD)

2-FULL NAME Elizabeth Crom

(a) RESIDENCE NO. 117 S. Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of ~~or WIFE of~~ Unknown

6 DATE OF BIRTH (month, day, and year) Jan 24, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65	66	3 8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Herself

9 BIRTHPLACE (city or town) St. Louis, Mo
(State or country)

PARENTS

10 NAME OF FATHER Charles Foster

11 BIRTHPLACE OF FATHER (city or town) St. Louis
(State or country) Mo

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant John Crom
(Address) 117 S. Payson

15 Filed AUG 10 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9 1927

17

I HEREBY CERTIFY, That I attended deceased from 8/6 1927 to 8/9 1927

that I last saw h[illegible] alive on 8/9 1927

and that death occurred, on the date stated above, at 1:15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2134 W Balto st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 11 1927

20 UNDERTAKER [illegible] ADDRESS 1100 W Lombard

CAUSE OF DEATH and PARTICULARS as to MEDICAL ATTENDANCE must be given in every case. See instructions on back of certificates.

IMPORTANT is very important.

Spec.—1-12-23—M&T—500 Blks.

E 24631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 24631

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 N Patterson Park Ave ST., 1910 WARD)

2-FULL NAME Edward S Will

(a) RESIDENCE NO. 524 N. Patterson Pk Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa Will

6 DATE OF BIRTH (month, day, and year): Feb 22-1859

7 AGE — Years: 68 — Months: 5 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Broom Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Manufactor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jake Will

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louisa Will

(Address) 524 N Patterson Pk Ave

15 Filed ... 19 ... C. HAMPTON JONES, M. D. Registrar

PAT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 19 27, to Aug 8, 19 27, that I last saw h alive on Aug 7, 19 27 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan P. Lemmon, M. D.

Aug 9, 19 27 (Address) 1811 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 10 19 27

20 UNDERTAKER: Jno C. Miller & Son — ADDRESS 2334 Jefferson

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

E 24632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 24632

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1616 Hartford Ave St., 9-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes E. Fehrer

(a) RESIDENCE NO. 1616 Hartford Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Fehrer

6 DATE OF BIRTH (month, day and year) April 13 - 1880

7 AGE — Years: 47 Months: 3 Days: 20 24 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Martin Millers

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Dora Jahn

13 BIRTHPLACE OF MOTHER (City or town)
(State or country) Germany

14 Informant Carrie K. Schoen
(Address) 1201 Federal St.

15 Filed AUG 10 1927, 19 HAMPSON JONES, M. D. Registrar

RRA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7 1927

17 I HEREBY CERTIFY, That I attended deceased from June 24 1927 to August 7 1927

that I last saw her alive on aug. 7 1927

and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Gall Bladder

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of July 6. 1927

Was there an autopsy? No

What test confirmed diagnosis? Pathological Report. St. Joseph Hospital

(Signed) Edgar P. Sandrock, M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem Date of Burial 8/10 1927

20 UNDERTAKER: D. Philip Herwig ADDRESS 2016 Orleans St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 10 1927

Cor.—12-9-25—A Co.—200 Blks.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24633

CERTIFICATE OF DEATH.

91-002 E 24633

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 818 E. Preston St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Crowe

(a) RESIDENCE NO. 818 E Preston St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 13 1839

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
88	87	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER John Crowe

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Neill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Miss Dawson

(Address) 818 E Preston St

15 Filed AUG 10 1927, 19 H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

(Signed) G C Yates M. D.

(Address) 1436 E Bway

Aug 9 27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial Aug 11 1927

20 UNDERTAKER Rita Wiedefeld ADDRESS 914 Greenmount Ave

If coroner or attending physician should be called, the fact should be stated. Any statement which may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24634

CERTIFICATE OF DEATH.

E 24634

115

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2722 Hartford St., 9-46 (Ward)

2-FULL NAME Estelle E. Harriman

(a) RESIDENCE NO. 2722 Hartford St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (Write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 29 1927

7 AGE: Years | Months: 7 | Days: 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Evan Harriman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mildred Finch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Evan Harriman

(Address) 2722 Harford Ave

15 Filed_____, 19____ C. HAMILTON JONES, M. D. Registrar

AUG 11 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

Aug 9 27 (signed) J. C. Jones M. D.

(Coroner)

(Address) 1436 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — Date of Burial: Aug 10 1927

20 UNDERTAKER: Robt J Turner — ADDRESS: 1642 Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 24635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12-9 E 24635

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 Overhill Rd ST.) (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar N Ash

(a) RESIDENCE NO. 520 Overhill Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Orphans

(c) Name of employer Court.

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Juliet C Reed

(Address) Tech Hill Md City

15 Filed ..... 19 ..... R H K, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-8 1927

17

I HEREBY CERTIFY, That I attended deceased from abt , 1927, to Aug 8th, 1927, that I last saw him alive on Aug 8th, 1927, and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Following illness from

Heart & Kidney disease

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H K Longaker, M. D.

, 19 (Address) 119 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Aug 11 1927

20 UNDERTAKER W M Routson

ADDRESS 2238 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

AUG 10 1927 C. HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

Garrett

E 24636 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. + 90 E 24636

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5919 N. Belair Rd. Raspeburg, Md. ST. 26-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Amanda Catherine Garrett

(a) RESIDENCE NO. 5919 N. Belair Rd., Raspeburg ST. 26th WARD White Hall Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ ~~(or)~~ WIFE of Benjamin Garrett

6 DATE OF BIRTH (month, day, and year) March 2, 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ... min.
79	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) White Hall, Md.
(State or country) Baltimore, County

PARENTS

10 NAME OF FATHER Richard Nelson

11 BIRTHPLACE OF FATHER (city or town) White Hall
(State or country) Baltimore County, Md.

12 MAIDEN NAME OF MOTHER Delila Wiers

13 BIRTHPLACE OF MOTHER (city or town) White Hall
(State or country) Baltimore County, Md.

14 Informant P. A. Garrett
(Address) 52 Southgate Ave

15 Filed AUG 10 1927, 19 Registrar R H K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Wednesday August 9 19 27

17 I HEREBY CERTIFY, That I attended deceased from December 20, 19 26, to August 9, 19 27,

that I last saw her alive on August 6, 19 27,

and that death occurred, on the date stated above, at 6:20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis and Myocarditis

(duration) Years yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. K. Wilkinson, M. D.

8/9 19 27 (Address) 5713 N. Belair Rd. Raspeburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Vernon Cemetery White Hall — DATE OF BURIAL Aug 11 1927

20 UNDERTAKER P. Markalunas Son — ADDRESS White Hall Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

A. HAMILTON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24637 + 97 [illegible] E 24637

1. PLACE OF DEATH 1700 Thomas Ave. REGISTERED NO. 15-60

CITY OF BALTIMORE: (No. ~~1700 Thomas ave~~ St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mitchell Catheart

(a) RESIDENCE NO. 1700 Thomas ave St. WARD White Hall Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12 1863

7 AGE — Years: 64 — Months: 1 — Days: 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md

PARENTS

10 NAME OF FATHER Thos. Lytle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md

12 MAIDEN NAME OF MOTHER Elenora Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Md

14 Informant: Mrs. Harry F. Robinson
(Address) 1700 Thomas ave

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1926, to August 9, 1927, that I last saw her alive on Aug. 9, 1927, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

arterio sclerosis with hypertension. senility

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. one ds.

18 Where was disease contracted if not at place of death? do not know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice L. Shannon, M. D.

(Address) 3300 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Vernon Cemetery White Hall Md. DATE OF BURIAL: Aug 12 1927

20 UNDERTAKER: P. Mahlenbrock ADDRESS: White Hall Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24638
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 S. Third St., (or) Ward) 26-37

2-FULL NAME John Wiegmann

(a) RESIDENCE NO. 903 S. Third St. 26 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara A. Wiegman

6 DATE OF BIRTH (month, day, and year) aug 16 1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
52 53	11	22		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Store

(b) General nature of industry, business, or establishment in which employed (or employer) Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Barbara A. Wiegmann
(Address) 903 S. Third St

15 Filed ..... 19 ..... Registrar

C. THOMPSON JONES, M. D.

AUG 10 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1927, to aug 8 1927, that I last saw him alive on 8/8 1927, and that death occurred, on the date stated above, at 10 35 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Roentgen

(Signed) C A Reed Schneider M. D.

8/9. 1927 (Address) 1937 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Sacred Heart Emmitsburg — aug 12 1927

20 UNDERTAKER — ADDRESS

Lilly & Zilen — 403 S. Wolfe St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24639

CERTIFICATE OF DEATH.

† 129 E 24639

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hosp. St., 4-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Doetzer

(a) RESIDENCE NO. Essex Md St._____ Ward Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo J Doetzer

6 DATE OF BIRTH (month, day and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Penna

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna

14 Informant Geo J Doetzer

(Address) Woodward Penna Md.

15 Filed.....19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Anemia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(Duration) yrs. mos. 2 ds.

Aug 8 27 (Signed) C C Hall M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemy Date of Burial Aug 11 1927

20 UNDERTAKER Lilly & Sons ADDRESS 1103 & 1105 W

AUG 10 1927 C. HAMPSON JONES M. D.

Don't write above this line. Fill in all blanks by typewriter or in ink. Print plainly. Be sure to have every item properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 24640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 7 E 24640

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Front of 1011 E. Howard St., (Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Fields

(a) RESIDENCE NO. Dont Know St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ever yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col	Dont Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37	about		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Stanley Fields

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER M Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Ida Huggins

(Address) 207 Baldwin St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and autopsy (Inquest, autopsy or inquiry.) the body and from the evidence obtained by said Inquest and autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cause unknown

Homicide

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed W. S. Culley M. D.

Aug 9 19 27 (Coroner) (Address) 1037 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middleburg County Va Date of Burial Aug 10 1927

20 UNDERTAKER Leonard M Hale ADDRESS 309 Myrtle Av.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CHESTER JONES, M. D.

AUG 10 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24641

CERTIFICATE OF DEATH.

E 24641

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Agnes Hospital (Ward)

2-FULL NAME Romwald Duttmiller

(a) RESIDENCE NO. 910 E. St. Sparrows Pt. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~Laborer~~ Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem

(c) Name of employer: Steel Co.

9 BIRTHPLACE (city or town)

(State or country): Pa

PARENTS

10 NAME OF FATHER: Harry Duttmiller

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Mrs. Duttmiller

(Address): 910 E. St. Sparrows Pt. Md

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest or inquiry.) thereon and from the evidence obtained by me (Inquest or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brain abscess

(duration) — yr. 2½ mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yr. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

Aug 9th, 1927 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See instructions on back of this sheet.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Johnstown, Pa.

Date of Burial: 8/10/ 1927

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E. Baltimore

Be sure to answer carefully every question. Any space which cannot be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OF DEATH in plain terms, so that it may be properly

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24642

CERTIFICATE OF DEATH.

E 24642

114

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 12-59 Ward)

2-FULL NAME Lovel L. Thornton

(a) RESIDENCE NO. 1214 W. Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys V. Thornton

6 DATE OF BIRTH (month, day, and year) Nov. 1897

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	29	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 3rd

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City

(c) Name of employer Fire Dept

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Franklin Thornton

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Hunt

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Gladys V. Thornton

(Address) 1214 W. Mosher Ave

15 Filed ..... 19 ..... C. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Hennessy M. D.

(Coroner)

Aug 7, 1927 (Address) 7502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Aug 11 1927

20 UNDERTAKER H. Cook ADDRESS 502 E. Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—11-23—A.T.—500 Bks.

Dr. Glenn Lakeland

E 24643

Spec.—1-12-23—M&T—500 Bks.

Dr. Glenn Lakeland

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24643

CERTIFICATE OF DEATH.

E 24643

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Belvedere Av (Street) Lakeland (WARD)

REGISTERED NO. 1 1 3 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Hinks

(a) RESIDENCE. No. Belvedere Av (Usual place of abode) Lakeland WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maud J Hinks

6 DATE OF BIRTH (month, day, and year): Feb 26 1872

7 AGE: Years 55 Months 10 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: B & O R.R Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Hinks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Maud J Hinks Lakeland

15 Filed Aug 10, 1927 C. HAMPTON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9 1927

I HEREBY CERTIFY, That I attended deceased from May, 1922, to Aug 9, 1927, that I last saw him alive on Aug 7 1927 and that death occurred, on the date stated above, at 4:30 pm

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Raymond D Orleans M. D.

Aug 9, 1927 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westernbeer Aug 11 1927

DATE OF BURIAL

20 UNDERTAKER: William Cook

ADDRESS 502 E Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks. (Misuraca)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24644 E 24644

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4109 Dalrymple Ave ST., (5-5 WARD)

2-FULL NAME Salvatore T. Misuraca

(a) RESIDENCE NO. 4109 Dalrymple Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 29, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	38	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Frank Misuraca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Johanna Rinaldi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Eugene Misuraca
(Address) 125 Eutaw Place

15 Filed ....., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10th, 1926, to Aug. 8th, 1927, that I last saw him alive on Aug 8, 1927, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. Leslie, M. D.

, 19 (Address) 756 W Fayette st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Aug 11 1927

20 UNDERTAKER W. Cook — ADDRESS 502 E Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24645

CERTIFICATE OF DEATH.

66 E 24645

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 2211 Penna Ave St. 14-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Phillip Grayson

(a) RESIDENCE NO. 2211 Penna Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Florence Grayson

6 DATE OF BIRTH (month, day, and year) Aug 15, 1901

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
25 23	26	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Wallace Grayson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Bessie Piper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Wallace Grayson

(Address) 2211 Pa Ave

15 Filed ..... 19 ..... C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1927

17

I HEREBY CERTIFY, That I attended deceased from July 29, 1927, to Aug 9, 1927, that I last saw h. alive on Aug 9, 1927, and that death occurred, on the date stated above, at 1030 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) 6 ? yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinalysis

(Signed) C. Wallace Gray, M. D.

(Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brandy Sta Va. Date of Burial Aug 10 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 503 Hesstman St

If not buried or cremated, state disposition. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24646

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 24646

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hopkins Hosp

CITY OF BALTIMORE: (No.) St Paul s 31st (ST.) 12-SD (WARD)

2-FULL NAME Mary L. Armistead

(a) RESIDENCE NO. St Paul s 31st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of John C. Armistead

6 DATE OF BIRTH (month, day, and year) July 24th 1839

7 AGE: Years 88; Months; Days 16; If LESS than 1 day, ... hrs or ... min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Alabama

PARENTS

10 NAME OF FATHER Thomas Keen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs Smith

(Address): Hopkins s 31st

15 Filed ... 19... Registrar

G 1927C HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 8 1927, to Aug 10 1927.

that I last saw her alive on Aug 9 - 4 P.M. 1927

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & course Bl. W.P.N. + Bl. sugar

(Signed) Jno A. Fletcher, M. D.

Aug 10 1927 (Address) 12 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Petersburg Va — DATE OF BURIAL: Aug 11 1927

20 UNDERTAKER: Henry Jenkins Sons — ADDRESS: Oct-Cor Eutaw & Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24647

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24647

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 N. Milton Ave ST. 8-17 WARD)

2-FULL NAME John Boland

(a) RESIDENCE NO. 1115 N. Milton Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bridget Boland

6 DATE OF BIRTH (month, day, and year): Sept 15 1831

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
95	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Boland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Boland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Edward McCrea

(Address) 1115 N. Milton Avenue

15 Filed ... , 19 ... Registrar

CHAMPION JONES, M. D.

AUG 10 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 8 1927

17

I HEREBY CERTIFY, That I attended deceased from June 5, 1927, to Aug 8, 1927,

that I last saw him alive on Aug 6, 1927,

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac Fisher, M. D.

8/10, 1927 (Address) 1823 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Charles Cemetery

DATE OF BURIAL: 8/10 1927

20 UNDERTAKER: George J Ruth

ADDRESS: 1756 Harford Ave

IMPORTANT—This certificate should be carefully typed. All items must be answered or the word "unknown" inserted. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24648

CERTIFICATE OF DEATH

88 E 24648

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2014 E Lombard St. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Klucz

(a) RESIDENCE. NO. 2014 E Lombard St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE — Years: 58 — Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Tomas Klucz

11 BIRTHPLACE OF FATHER (City or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Julia Rychwalski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Apalonia Klucz

(Address) 2014 E Lombard St

15 Filed AUG 10 1927 19 — C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Aug. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1927, to Aug. 9, 1927, that I last saw him alive on Aug 9 1927, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Acute P. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute myocarditis.

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Chas S Mentzer, M. D.

, 19 (Address) 1730 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — Date of Burial: Aug 13 1927

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24649

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3616 Cedar Ave (WARD) 13-52

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margret E Wickens

(a) RESIDENCE NO. 3616 Cedar Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E Wickens

6 DATE OF BIRTH (month, day, and year) March 13 1878

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER William H.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Cecilia Stiffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant (Address) James E Wickens 3616 Cedar Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8—9—1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1927, to Aug. 8, 1927.

That I last saw her alive on Aug 8, 1927.

And that death occurred, on the date stated above, at 1.30a m.

The CAUSE OF DEATH* was as follows:

Mammary Carcinoma (Left)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Toxemia of Pregnancy

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 6 mos. ago.

Was there an autopsy? No

What test confirmed diagnosis? Microscopic.

(Signed) W. H. Smith for Nathan W Lupton, M. D.

, 19 (Address) 1900 Mt Royal Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove Baltimore — DATE OF BURIAL Aug 11 1927

20 UNDERTAKER Chenowith & Son — ADDRESS 3617 Chestnut

TION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

H E 24650

38 E 24650

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 12-51 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Heberle

(a) RESIDENCE NO. 2611 Bernard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE 57 Years Months Days IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Alabama

(State or country)

PARENTS

10 NAME OF FATHER Chas W. Heberle

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Patient

(Address)

15 Filed ..., 19... C. HINSON JONES, M. D. Registrar

AUG 11 1927 Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1927, to Aug 9, 1927, that I last saw him alive on Aug 9, 1927, and that death occurred, on the date stated above, at 1.00 A m.

The CAUSE OF DEATH was as follows:

Syphilis
Aortic Insufficiency
Chr Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys findings

(Signed) C. Sulmeda Bonifacio, M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Marys Aug 11 1927

20 UNDERTAKER — ADDRESS

Chenowith Son 867 Chestnut

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUP very important. See instructions on back of certificates.

E 24651

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-E 24651

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 13-57 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. Welch Jr.

(Residence in Baltimore: No. 1308 Dellwood Ave. St. 1 yrs. 4 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Single

6-DATE OF BIRTH.

March (Month) I4 (Day) I926 (Year)

7-AGE. I yrs. 4 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. William T. Welch

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Catherine R. Lippy

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William T. Welch

(Address) 1308 Dellwood Ave.

15-

Filed ..... 192.. C. HAMPSON JONES, M. D.

Per ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August (Month) I0 (Day) 192.7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) C. O'Reilly M. D.

(Address) 1436 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St, Mary's Hampden

DATE OF BURIAL. Aug. I2 1927

20-UNDERTAKER. Horace H. Burgee

ADDRESS 3631 Falls Road

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24652

CERTIFICATE OF DEATH

90 E 24652

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5905 York Road St. 47-48 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. France

(a) RESIDENCE NO. 5905 York Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4, 1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. County (State or country) Md.

PARENTS

10 NAME OF FATHER Rev. Joseph France

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Susan S. Eaham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Charles Murrigan

(Address) 224 E. Saint Paul St.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927, to Aug 9, 1927.

That I last saw her alive on Aug 9, 1927.

and that death occurred, on the date stated above, at 7. A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Cancer

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No test.

(Signed) Geo. W. Jackson, M. D.

8/9, 1927 (Address) 5835 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Olivet Cemy.	Aug 11 1927
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	1900 E. Saint Paul St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

11 1927 C. Harrison Jones, M.D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24653

CERTIFICATE OF DEATH

+ 199

E 24653

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. 14-30 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Carrie Daye

(a) RESIDENCE NO. Pikesville Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ~~35~~ yrs. mos. 8 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo Day

6 DATE OF BIRTH (month, day, and year): July 24 1892

7 AGE: Years 35 Months Days 16 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Gustave Hornlein

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Laura Eichloff

13 BIRTHPLACE OF MOTHER (City or town)

(State or country): Germany

14 Informant: Geo. Day

(Address): Pikesville Md

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

AUG 11 1927 By R.K.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1927, to Aug 10, 1927, that I last saw her alive on Aug 10, 1927, and that death occurred, on the date stated above, at 8 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Puerperal Infection, following abortion (self induced).

Septicemia (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? Pikesville Md.

Did an operation precede death? Yes Date of Aug 3, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lewis Adams Paynter, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Cem	Aug 12 1927
20 UNDERTAKER	ADDRESS
John O. Sinkhorn Sons	1401 Eutaw Place

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24654 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24654

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 N. Curley ST. 8-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Speiker

(a) RESIDENCE NO. 1213 N Curley ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 12/27, 1926

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto — Md.

PARENTS

10 NAME OF FATHER Harry Speiker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Marie Hook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry Speiker (Address) 1213 N Curley St

15 Filed AUG 11 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 8, 1927, to Aug 9, 1927.

that I last saw him alive on Aug 9, 1927

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion - Bronchopneumonia

Chronic Interstitial Pneumonia

Emphysema

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

Edema (duration) yrs. 11 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm E Geppert, M. D.

, 19 (Address) 156 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 8/10 1927

20 UNDERTAKER George J Ruth — ADDRESS 1730 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

E 24655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 24655

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2322 E. Fairmount Ave St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. L. Feller

(a) RESIDENCE NO. 2322 E. Fairmount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Sophia K. Feller

6 DATE OF BIRTH (month, day, and year): Jan 21/48

7 AGE: Years 79 Months 6 Days 19

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Real Estate Agent

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Chas. Feller

11 BIRTHPLACE OF FATHER (City or town): Ger

(State or country)

12 MAIDEN NAME OF MOTHER: Louisa

13 BIRTHPLACE OF MOTHER (city or town): Ger

(State or country)

14 Informant: Harry C. Feller

(Address) 2322 E. Fairmount Ave

15 Filed ....., 19 .....

Registrar

Per

AUG 11 1927 C. EARSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Aug 9/27

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 1927, to Aug 9 1927, that I last saw h alive on Aug 8 1927, and that death occurred, on the date stated above, at 3:35 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Uremia

(duration) 4 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. S. Amy M. D.

8/11/27 (Address) 677 N. Mt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Butte Cem. Date of Burial 8/11 1927

20 UNDERTAKER: Philip Henry ADDRESS 2016 Orleans

tion should be carefully supplied. AGE should be s
OF DEATH in plain terms, so that it may be proper
very important. See instructions on back of certific

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24656

CERTIFICATE OF DEATH.

99-901 E 24656

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 530 Conway St. 12-30 Ward)

2-FULL NAME Wm. Gray.

(a) RESIDENCE NO. 530½ Conway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9-1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer

9 BIRTHPLACE (city or town) N. C.

(State or country)

PARENTS

10 NAME OF FATHER William Gray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) N. C.

(State or country)

14 Informant William Gray

(Address) 530 N. Conway St

15 Filed 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Bronchitis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) Augs G Wades M. D.

(Coroner)

(Address) 543 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Calvary	Aug 11-1927

20 UNDERTAKER R. L. Parham ADDRESS 1216 E. Shaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 11 1927 C. HAMILTON JONES, M.

Spec—12-23-21—F P R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24657 ✓ 161-00r E 24657

CERTIFICATE OF DEATH.

E 24657

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. University Hospital St., 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Baby Boy Smack.

(a) Residence No.... 906 N. Saratoga St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black.

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 8/5/27.

7-AGE, ...yrs. ....mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Samuel Andrews

11-BIRTHPLACE OF FATHER (city or town) (State or Country). North Carolina.

12-MAIDEN NAME OF MOTHER, Mildred Smack

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). New Jersey

14-

(Informant).....

(Address).....

15-

Filed ..... 192.....

C. HAMILTON JONES, M. D. AUG 1 1927

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 6, 1927

17- I HEREBY CERTIFY, That I attended deceased from 8/5 1927 to 8/6 1927

that I last saw h. alive on 8/6/27 19.....

and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia (Bilateral)

.....(Duration) ....yrs. ....mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Geo. T. Hobbetts M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Crem'd University Hospital

DATE OF BURIAL, 8/6/ 1927

20-UNDERTAKER,

ADDRESS

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—560 Blks.

Forensic
St-Paul + 25

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24658

CERTIFICATE OF DEATH.

94-001

REGISTERED NO. E 24658

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Calvin ST. 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F Doyle

(a) RESIDENCE NO. 902 Calvin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret —

6 DATE OF BIRTH (month, day, and year) Dec 25 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) N. Y. State

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs Emma Fuerst (Address) 902 Calvin

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1927

17

I HEREBY CERTIFY, That I attended deceased from July 4, 1927, to July 9, 1927,

that I last saw her alive on July 9, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy + Hemiplegia

(duration) 1 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 4 yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) J. Strudley Gorman M. D.

July 10, 1927 (Address) 902 Calvin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fair Cathedral	July 12 1927

20 UNDERTAKER Hamm Cook ADDRESS 502 E. Hamm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

AUG 11 1927 G. HAMILTON JONES, M.D.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 ✓

E 24659

REGISTERED NO. E 24659

1-PLACE OF DEATH

City of BALTIMORE: (No. 3817 Barrington Road, St. 15-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth (Lizzie) Eilau

(a) RESIDENCE NO. 3817 Barrington Road. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby. 19th. 1849.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	78	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Md.

PARENTS

10 NAME OF FATHER William Eilau

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Bitter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Isaac Frank.

(Address) 3817 Barrington Road

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1927 to Aug 10 1927

that I last saw h[illegible] alive on Aug 9 1927

and that death occurred, on the date stated above, at 1 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

heart home

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Industrial Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. C. Samuels, M. D.

(Address) 4509 Liberty Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Hebrew Friendship Cem.	8/12/ 1927

20 UNDERTAKER David Sondheim

ADDRESS 115 Lombard Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. MARGIN should be carefully supplied. AGE tion should be carefully supplied. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

AUG 11 1927

Spec.–7-17-26—A Co.—200 Bks.

Robert Duncan

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001 ✓

CERTIFICATE OF DEATH

E 24660
1-PLACE OF DEATH

E 24660
REGISTERED NO.

City of BALTIMORE: (No. Old Gunston pl 2 W-63 Street (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Duncan

(a) RESIDENCE NO. 4105 Barrington Rd Ward
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Rosa Duncan

6 DATE OF BIRTH (month, day, and year): 7/24/1849

7 AGE: Years 78 Months 7 Days 16 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Jeffersonville Ill
(State or country)

PARENTS

10 NAME OF FATHER: Wm D Duncan

11 BIRTHPLACE OF FATHER (City or town): Balto
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Romney

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country)

14 Informant (Address): Mrs Rosa Duncan

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.
AUG 11 1927
Dep.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/11/27 19

17 I HEREBY CERTIFY, That I attended deceased from 7-25-27 to 8/11/27 19 ..... ; that I last saw h.. alive on 8/11/27 19 ..... ; and that death occurred, on the date stated above, at 2:58 a m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Pr.
Gl. Uremia
Exhaustion
(duration) ..... yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility & Cardiac Insufficiency
(duration) ..... yrs. mos. ds.

18 Where was disease contracted: Home
If not at place of death? .....
Did an operation precede death? No Date of 7/24/27
Was there an autopsy? .....
What test confirmed diagnosis? Clinical

(Signed) Jno A Duncan M. D.
. 19 (Address) 1 E Lexington St

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery Date of Burial 8/12 1927

20 UNDERTAKER: Chas P. Friand & Son ADDRESS 118 N Whitt Royal Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 24661

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24661

CERTIFICATE OF DEATH.

(Reported as Otha Stewart)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 54 Mission Court (ST.) 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stewart Lee

(a) RESIDENCE NO. 54 Mission Court ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bells Md

PARENTS

10 NAME OF FATHER Thomas Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Anita Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Anita Lee

(Address) 809 N. Calhoun St

15 Filed AUG 11 1927 C. HAMILTON JONES M. D.

Per R P K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10th 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 9th, 1927, to Aug 10th, 1927,

that I last saw h alive on Aug 10th, 1927,

and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Entero-Colitis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Harry F Brown, M. D.

(Address) 916 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Aug 11 1927

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than 1 day CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24662

CERTIFICATE OF DEATH.

188-003

REGISTERED NO. E 24662

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Terrace St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Brady Jr.

(a) RESIDENCE NO. 1125 N. Monroe St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14, 1926

7 AGE Years 1 Months 3 Days 4 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER James Brady

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Severia Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant James Brady.
(Address) 1125 N. Monroe St

15 Filed....., 19 C. HANSON JONES, M. D.
Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
(accidental)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Automobile accident

(duration) yrs. mos. ds.

(Signed) J. [illegible] M. D.
(Coroner)

19 27 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

(Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial aug 11 1927

20 UNDERTAKER Thomas G. Kelson ADDRESS 1393 Pennsylvania Ave

AUG 11 1927

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46

E 24663

CERTIFICATE OF DEATH.

Wyke Ave Extended E 24663

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgecomb Park ST. 27-36 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Waxter

(a) RESIDENCE NO. Edgecomb Park ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write this word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Waxter

6 DATE OF BIRTH (month, day, and year) Mar. 27, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	70	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Christopher Mosner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover

12 MAIDEN NAME OF MOTHER Marie Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Howard E. Waxter

(Address) Edgecomb Park

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1. 1926. to Aug 9 1927.

that I last saw h alive on Aug. 9 1927.

and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

I Cancer of uterus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) James L. Ashmead M. D.

8-11-1927 Address 1012 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL Aug 11 1927

20 UNDERTAKER Wm J. Pickett & Sons ADDRESS North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

E. HAWKINS JONES, M. D.

AUG 11 1927

R.C.C.

Spec.—1-10-21—M&T—1500 Bks.

E 24664

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24664

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 0629 Liberty Heights St. (Ward)

2-FULL NAME Rosie C Bonnet

(a) RESIDENCE NO. 3629 Liberty Heights St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmd

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert H Bonnet

6 DATE OF BIRTH (month, day, and year): April 8 1862

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
65 ~~7~~	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Chas Spielman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Feldmeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt

14 Informant (Address): Mrs Charles Zimmerer 3629 Liberty Heights Ave

15 Filed ..., 19 ... Registrar: RMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1927, to Aug 10, 1927, that I last saw h alive on Aug 9, 1927, and that death occurred, on the date stated above, at 5 a, m.

The CAUSE OF DEATH* was as follows:

Cardio Carcinoma, 4 mo

(duration) yrs. 4 mos. 2 ds.

CONTRIBUTORY (Secondary): Carcinoma Uterus

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path

(Signed) John H Evans, M. D.

19 (Address) 612 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ZANESVILLE. OHIO

DATE OF BURIAL: 8-12 1927

20 UNDERTAKER: Mrs Chas G Rohde

ADDRESS: 2327 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24665

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24665

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH City of BALTIMORE: (No. Union Mem'l Hosp. St., 18-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Fugate

(a) RESIDENCE NO. 1044 W. Fayette St. Ward Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 21-1927

7 AGE: Years 0 Months 5 Days 17 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Jack Fugate

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ky.

12 MAIDEN NAME OF MOTHER Hilda Stakes

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Indiana.

14 Informant mother

(Address) 1044 W. Fayette St.

15 Filed ..... 19 ..... Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:*

1 Acute

2 Broncho. Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) G. Laustrup

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Hall M. D.

(Coroner)

8/27 19 (Address) 143 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va. Date of Burial 8-12 1927

20 UNDERTAKER Fred A. Cole ADDRESS 1411 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 24666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29E 24666

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1213 Park Ave ST. 11-24 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine H White

(a) RESIDENCE. No. 1213 Park Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 2 ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm H. White

6 DATE OF BIRTH (month, day, and year): Sept 15 1865

7 AGE: Years 61 Months 10 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Washington D C

PARENTS

10 NAME OF FATHER: Geo Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Wm H White
(Address) Fairview Hallstown W Va

15 Filed . 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10, 1927

17

I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to Aug 10, 1927, that I last saw her alive on Aug 9, 1927, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Bed

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pettigrew M. D.

. 19 (Address) 517 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charleston W Va — DATE OF BURIAL: Aug 12. 1927

20 UNDERTAKER: Franklin H Seitz — ADDRESS: 709 W 33d St.

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 24667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 24667

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Davis -

(a) RESIDENCE NO. 820 N Bond. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1912

7 AGE: 15 Years Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): School girl

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Chas Davis

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Harris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Mary Harris

(Address) 820 N. Bond St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-9-27

17 I HEREBY CERTIFY, That I attended deceased from 2-18-, 1927, to 8-9-, 1927

that I last saw h[illegible] alive on 8-9, 1927,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Left

Acute Dyspepsia Neglected

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — Date of Burial: Aug 13 1927

20 UNDERTAKER: Mrs R. A. Elliott — ADDRESS 1525 Eastland Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HAMILTON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 24668

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24668

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 7 Franklin Square) (ST.) 27-48 (WARD)

2-FULL NAME Baby Boy Wastler.

(a) RESIDENCE NO. 407 Maryland Ave (ST.) (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 40 min. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 10 '27

7 AGE: Years | Months | Days | If LESS than 1 day hrs. or 7 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Lloyd Wastler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Beulah Evernam

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Beulah Wastler.

(Address) 407 Maryland Ave Govans

15 Filed , 19 1644 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1927. to Aug 10, 1927.

that I last saw h alive on Aug 10, 1927

and that death occurred, on the date stated above, at 9 20/2 m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Placenta Previa

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Bryan, M. D.

8/10, 1927 (Address) 1837 Eutaw ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: C. W. G. Rohrer M.D.

DATE OF BURIAL: Aug 10 1927

20 UNDERTAKER: State Board of Health.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE OR CONDITION is very important. See instructions on back of certificates.

218

AUG 11 1927 C. HAMPSON JONES, M. D.

Registrar of Vital Statistics

Spec.–7-17-26—A Co.—200 Bks.

E 24669 ~~24669~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+100-801 E 24669

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Cal Christian Andersen

(a) RESIDENCE NO. Hotel Jensen St. Ward Portsmouth Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operating Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Denmark

(State or country)

PARENTS

10 NAME OF FATHER Peter Andersen

11 BIRTHPLACE OF FATHER (City or town) Denmark

(State or country)

12 MAIDEN NAME OF MOTHER Christine Olsen

13 BIRTHPLACE OF MOTHER (city or town) Denmark

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to Aug 9, 1927, that I last saw him alive on Aug 9, 1927, and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Subacute Ulcerative Colitis

(duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (terminal)

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 13, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Raymond Wing, M. D.

. 19 (Address) Johns Hopkins Hospital Baltimore, Md.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmell — Date of Burial 8/11/27

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAU OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24670

CERTIFICATE OF DEATH

117

E 24670

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Genl Hospital St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Marshall

(a) RESIDENCE NO. Port Deposit, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: R. B. Marshall

6 DATE OF BIRTH (month, day, and year): 12-18-1865

7 AGE: Years 61 Months 7 Days 23 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: HW

(b) General nature of industry, business, or estahlishment in which employed (or employer): O

(c) Name of employer

9 BIRTHPLACE (city or town): Cecil Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Anthony Hompson

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca Buckley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: R. B. Marshall

(Address): Rising Sun, Md.

15 Filed ..., 19 ... Registrar RFH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-11-27 19

17 I HEREBY CERTIFY, That I attended deceased from 7-19-27, 19, to 8-11-27, 19, that I last saw her alive on 8-11-, 1927, and that death occurred, on the date stated above, at 1:25 p. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

Acute Cardiac Dilatation Dropsy 15 minutes

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-20-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

, 19 (Address) Md. Genl Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hopewell Cem, Cecil Co Md Date of Burial 1927

20 UNDERTAKER: Lee A. Patterson ADDRESS: Perryville Md

1. Items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 11 1927

Spec—12-23-21—E.B.R.S.—400 Bks.

E 24671

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24671

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1913 W. Baltimore 26 Registered No.

City of BALTIMORE: (No. 1913 St., W. Baltimore 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Louis Lepson

(a) Residence No. 1913 W. Baltimore 26 St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mand. A. Lepson

6-DATE OF BIRTH (month, day and year) Oct. 6-1890

7-AGE 36 yrs. 10 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clothing Cutter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, Geo. W. Lepson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Alice McCready

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14-

(Informant) Mrs. Mand A. Lepson

(Address) 1913 W. Baltimore 26.

15-

Filed ..... 192 .....

C. HAMPSON JONES, M. D. Registrar.

By .....

In plain terms, so that it may be properly classified. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 10. 1927

17- I HEREBY CERTIFY, That I attended deceased from May 10. 1927 to Aug 10 1927

that I last saw h. alive on Aug 10 1927

and that death occurred, on the date stated above, at 12104

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Inoperable

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Obstruction Intestinal

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 11 27

Was there an autopsy? No.

What test confirmed diagnosis? Exploratory

(Signed) [illegible] M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cemetery DATE OF BURIAL, Aug 13. 1927

20-UNDERTAKER George L. Schmidt ADDRESS 1104 Eutaw Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 24672

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24672

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 N. Mt. Dulloh St. 11-24 Ward) 57

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lucy Ford

(a) Residence No. 1104 N. Mt. Dulloh St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, Widow or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1881

7-AGE. 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED:

(a) Trade, profession, or particular kind of work. Housework ~~Housework~~

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. Leo Spriggs

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Mc Kinnon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14-(Informant) Lucie Savage

(Address) 606 Dolphin St

15-

Filed 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 11-4 A.M.

17- I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to Aug 11th, 1927, that I last saw h[illegible] alive on Aug 8th, 1927, and that death occurred, on the date stated above, at 4—A—m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? At house of death

Did an operation precede death? No Date of

Was there an autopsy? Clinical analysis

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

, 19 (Address) 0937 N. Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn Cem	Aug 6th 27
20-UNDERTAKER	ADDRESS
Daniel Easton	City

Exact statement of OCCUPATION is very important. Fill in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 24673

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24673

CERTIFICATE OF DEATH

129

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 508 N. Carrollton Ave) (St. or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Francis Hawkins

(a) RESIDENCE NO. 508 N. Carrollton Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Hawkins

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (a) Lawn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Aaron Thomas

11 BIRTHPLACE OF FATHER (City or town) Charles Co

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Cassie Hodges

13 BIRTHPLACE OF MOTHER (City or town) Baltimore

(State or country) Maryland

14 Informant Nellie Thomas

(Address) 508 N. Carrollton

15 Filed . 19 Registrar

JUN 1 1927 C. CAMPBELL JONES, M.D.

NKB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/1, 1927, to 8/10 27.

that I last saw her alive on 8/9 19 27.

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. nephritis + arteriosclerosis (Chronic)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) David Francis M. D.

8/10 1927 (Address) 122 N. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Auburn Cem.	Aug 12 1927
20 UNDERTAKER	ADDRESS
Daniel Easton	Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24674 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24674

CERTIFICATE OF DEATH.

90

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 Plowman ST., 3-5 WARD)

2-FULL NAME Louise Flannery

(a) RESIDENCE NO.... 811 Plowman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Michael Flannery

6 DATE OF BIRTH (month, day, and year) May 27th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	57	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Samuel Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Louise Donaldson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mrs. John E. Stone 811 Plowman St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9th 1927

17

I HEREBY CERTIFY, That I attended deceased from May 15 , 1927 , to Aug. 9 , 1927 , that I last saw her alive on Aug 2 , 1927 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. arterio. sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. J. Donovan , M. D.

, 19 (Address) 3035 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	8/12/1927

20 UNDERTAKER E. J. Fanning & Son ADDRESS 1386 Lafayette Ave

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that i
TION is very important See instructions on

AUG 11 1927 C. HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24675

CERTIFICATE OF DEATH.

38

E 24675
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Balto. General Hospital 31 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Charles Coates

(a) RESIDENCE NO. 111 N. Hill St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Betty Coates

6 DATE OF BIRTH (month, day, and year) [illegible] 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steveduse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Calvt Co Md

PARENTS

10 NAME OF FATHER James Coates

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Calvt Co Md

12 MAIDEN NAME OF MOTHER Julia —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Calvt Co Md

14 Informant Betty Coates

(Address) 111 Wolfe St

15 Filed ..... 19 ..... Registrar

AUG 12 1927 RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 5th, 19 27, to Aug 10, 19 27

that I last saw h~~im~~ alive on Aug 10, 19 27

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Luetic Meningitis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann of Bl. + S. F.

(Signed) William W. Cebrace, M. D.

, 19 (Address) South Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Inland Cmtb. Aug 14, 27

20 UNDERTAKER Calvt Co. Md ADDRESS 1027

John H. Trodden Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24676
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

88 E 24676
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1051 W Baare ST. 21-29 WARD)

2-FULL NAME John Shater

(a) RESIDENCE NO. 1051 W Baare ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of Laura V Shater

6 DATE OF BIRTH (month, day, and year) May 4 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	52	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 916

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John L Shater

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalena Paur

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Laura. Shater (Address) 1051 W Baare St.

15 Filed ....., 19 R H K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 25. 1927. to Aug 10. 1927.

that I last saw him alive on Aug. 10. 1927.

and that death occurred, on the date stated above, at 2. a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis Acute

(duration) 0 yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilitation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation preeede death? NO Date of

Was there an autopsy? - NO -

What test eonfirmed diagnosis? Clinical

(Signed) M C Finnegan M. D.

19 (Address) 682 N Mt. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	8/12 192

20 UNDERTAKER Enoch Farley Sulem & Sayder ADDRESS

TION is very important · See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24677

CERTIFICATE OF DEATH.

118-001 E 24677

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 333 E - 25th. (ST.) 12-50 (WARD)

2-FULL NAME Sarah Isabel Mackey

(a) RESIDENCE NO. 333 - E - 25th. ST. (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane W Mackey.

6 DATE OF BIRTH (month, day, and year) Sept. 16 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	10.	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Chas Bentley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn—

12 MAIDEN NAME OF MOTHER Amy Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

14 Informant Mrs Frank Ross

(Address) 333 25th St

15 Filed AUG 12 1927 19 C. HAVEN JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1 .1927. to Aug 9 .1927.

that I last saw h e alive on Aug 9 .1927.

and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Chr - Interstitial Nephritis

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Operation - Strangulated Hernia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 24/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. White Jr. M. D.

8/11. 1927 (Address) 1815 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem. DATE OF BURIAL Aug. 12 1927

20 UNDERTAKER Wm Cook ADDRESS 507 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24678

CERTIFICATE OF DEATH.

159-00

E 24678

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 109 N. Curley St. 6-11 WARD)

2-FULL NAME Carl Charles Willner

(a) RESIDENCE. No. 109 N. Curley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29 1927

7 AGE Years 1 Months Days 11 42 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Fredrick Willner

11 BIRTHPLACE OF FATHER (city or town) City (State or country)

12 MAIDEN NAME OF MOTHER Annie Long

13 BIRTHPLACE OF MOTHER (city or town) City (State or country)

14 Informant Fred. Willner (Address) 109 N. Curley St.

15 Filed AUG 12 1927 19 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 9. 1927 to Aug 10 1927 that I last saw him alive on Aug 10 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Congenital malformation of Heart (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Autopsy

(Signed) H. Kemp Hurley M. D.

8-11 1927 (Address) 2535 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL 8/12/1927

20 UNDERTAKER J. A. Moran — ADDRESS 3000 E. Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24679

90 E 24679

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] St., 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Banks Or Henry Bangs

(a) RESIDENCE NO. 115 No Potomac St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 75 58 Years Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) New Orleans La.

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Patient

(Address)

15 Filed AUG 12 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-10 1927

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to Aug 10, 1927, that I last saw him alive on Aug 10, 1927, and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Arterio-selfrosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) C. Lenhard Boyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem Date of Burial: Aug 13 1927

20 UNDERTAKER: John Lucas & Son ADDRESS: 2008 Orleans

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24680

CERTIFICATE OF DEATH

129 ✓

E 24680

REGISTERED NO.

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS 08-31

City of BALTIMORE: (No. [illegible] St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dinon Livingston

(a) RESIDENCE NO. 2296 W. Henrietta St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long In U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Livingston

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE 43 Years Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina

(State or country)

PARENTS

10 NAME OF FATHER unable to get

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Wife

(Address)

15 Filed 19

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-11 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-9 1927 to 8-11 1927.

that I last saw him alive on 8-11 1927.

and that death occurred, on the date stated above, at 8:00 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Chronic myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) C. [illegible] M. D.

(Address) BALTIMORE CITY HOSPITALS

[redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn et — Date of Burial: Aug 14 19 27

20 UNDERTAKER: J. E. Brown's Son — ADDRESS: 1631 W. Monroe St

[illegible] JAMES ON JONES, M. D.

AUG 12 1927

This Should be carefully supplied. Note should be taken that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24681

CERTIFICATE OF DEATH

100-001

E 24681

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals St. 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stoney Crane

(a) RESIDENCE NO. Le Plante S. D. St. Ward Non Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Indian

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 30 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Indian Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Ind Ranch

(c) Name of employer

9 BIRTHPLACE (city or town) South Dakota
(State or country)

PARENTS

10 NAME OF FATHER Jerry Crane

11 BIRTHPLACE OF FATHER (City or town)
(State or country) S Dak

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Balto city hospital
(Address)

15 Filed AUG 12 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
8-9-27

17 I HEREBY CERTIFY, That I attended deceased from 8-3- , 19 27 , to 8-9- , 19 27

that I last saw him alive on 8-9- , 19 27

and that death occurred, on the date stated above, at 8.05 a. m.

The CAUSE OF DEATH* was as follows: Acute Dysentery Nephritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W Meynell M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery — Date of Burial: aug 12 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 1691 Orleans St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 12 1927 HARRISON JONES M D

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24682

CERTIFICATE OF DEATH.

90 E 24682

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 835 Warner St. 21-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Brashears Lee

(a) RESIDENCE NO. 835 Warner St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis

(State or country)

PARENTS

10 NAME OF FATHER W. Brashears

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Annapolis

12 MAIDEN NAME OF MOTHER Emma Coates

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Daughter of above

(Address) 835 Warner St

15 Filed AUG 12 1927, 19 C. HAMPSON JONES, M. D.

By RKK Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv disease Heart

Duration

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

(Signed) W J Riley M. D.

(Coroner)

(Address) 1059 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion cem Aug 13 27 Date of Burial

20 UNDERTAKER Leon Hall ADDRESS 715 Dolphin St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Jaworsky

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24683

CERTIFICATE OF DEATH

20 E 24683

1-PLACE OF DEATH

City of BALTIMORE: (No. Harrison Hosp St. 19-29 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jaworsky

(a) RESIDENCE NO. 325 S. Goodyear St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 11th 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	2	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Michael Jaworsky

11 BIRTHPLACE OF FATHER (City or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Maria Jaworska

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Michael Jaworsky

(Address) 325 S. Goodyear St.

15 Filed ..... 19 .....

AUG 12 1927 C. HAMPSON LEE, M.D. Registrar

Aug 12 1927 Pur RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/7, 1927, to 8/10, 1927, that I last saw him alive on 8/10/27, 1927, and that death occurred, on the date stated above, at 9 A.M. The CAUSE OF DEATH* was as follows:

Brain Abscess.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Otitis ?

(duration) Long ? yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. B. Teague M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial Aug 12th 1927

20 UNDERTAKER Mr Jones — ADDRESS W. S. Gilmor St

tion should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. If LESS than 1 day, hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 24684

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 N. Edau ST.; 9-17 WARD) REGISTERED No. C 47

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen C. Elgert

(Residence in Baltimore: No. 1531 N. Edau St.: 61 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. June (Month) 12 (Day), 1866 (Year)

7-AGE, 61 yrs. 1 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, James Connelly

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Marg. Kirlin

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Elgert

(Address) 1531 N. Edau St

15-

Filed AUG 12 1927, 191

C. HAMPSON JONES, M. D.

Per Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 11 (Day), 1927 (Year).

17- I HEREBY CERTIFY, That I attended deceased from August 1926, to Aug 1927, that I saw her alive on Aug 11 1927, and that death occurred, on the date stated above, at 10A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

8.11, 1927 (Address) 2739 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	Aug. 16, 1927
20-UNDERTAKER	ADDRESS
J. A. Weaver & Son	703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24685

CERTIFICATE OF DEATH.

113 E 24685

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital W-3 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rita Bernadzikowski

(a) RESIDENCE NO. 2324 First St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 7 - 27

7 AGE: Years | Months: 3 | Days: 13 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Same

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Baltimore

12 MAIDEN NAME OF MOTHER: L. Korzenowska

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Baltimore

14 Informant: A. Bernadzikowski

(Address) 2324 First St

15 Filed....., 19.....

AUG 12 1927 C. HAMPSON JONES

RKK Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) E. Claussen M. D.

11/27 (Address) 143 N. Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Aug 12 — 1927

20 UNDERTAKER: F W Ozazewski ADDRESS 1930 Eastern Av.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24686

CERTIFICATE OF DEATH

1929 E 24686

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2II S Gilmor St., St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie D. Poulton

(a) RESIDENCE NO. 2II S Gilmor St., St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert L. Poulton

6 DATE OF BIRTH (month, day, and year)
Aug 19, 1881

7 AGE	Years	Months	Days 20
	45	II	21

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 027

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER James E. Wright

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Sarah E. Connelly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Robert L. Poulton,

(Address) 2II S Gilmor St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

AUG 12 1927 Per RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

August 9th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 28th 19 27 to August 9th 19 27

that I last saw h[er] alive on August 8th 19 27

and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic nephritis 2

Myocarditis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) F. E. Poulton M. D.

8/10 1927 (Address) 3909 Gunston Blvd

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial Aug 12 1927

20 UNDERTAKER Harry G. Watts — ADDRESS 153 N Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24687

CERTIFICATE OF DEATH

90

E 24687

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals 1-24 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Thomas

(a) RESIDENCE NO. none given 903 Bolton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE 75 Years Months ? Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) Georgia
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Georgia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) ?

14 Informant Patient
(Address) 903 Bolton St.

15 Filed AUG 12 1927, 19 .. Per Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-10 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-2, 1927, to 8-10, 1927, that I last saw her alive on 8-10, 1927, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Chronic Hypocondritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Holmes Gwynn, M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Calvary cemetery — Date of Burial 8/13 1927

20 UNDERTAKER Eugene Payne — ADDRESS 510 W. Fulton St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 24688

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24688

CERTIFICATE OF DEATH.

16-22162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1117 N. Stricker St.; WARD:

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marshall Williams, Jr.

(a) RESIDENCE. No. 1117 N. Stricker St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos ... ds

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug. 11, 1927

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Marshall Williams Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Mary Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert County Md.

14 Informant: Mary Williams (Address) 1117 N. Stricker St.

15 Filed AUG 12 1927 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 11 1927.

17

I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1927, to Aug. 11, 1927, that I last saw him alive on Aug. 11, 1927, and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

10 minutes

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Quinn, M. D.

8/11 1927 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Aug 12 1927

20 UNDERTAKER: Virginia J. Brooks — ADDRESS: 1705 E. Pres

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24689

CERTIFICATE OF DEATH.

74-002
74 E 24689

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 W. Fayette ST. 14-27 WARD)

2-FULL NAME Joseph Francis H. Tiralla

(a) RESIDENCE NO. 1728 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise C. Tiralla

6 DATE OF BIRTH (month, day, and year) Dec.5,1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Publisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry M. Tiralla

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz. Habbersett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Louise Tiralla

(Address) 1728 W. Fayette St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10. 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 6. 1927 to August 10, 1927.

that I last saw him alive on August 10, 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis 2 Mos.

Cerebral Thrombosis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Evan Woodlaken, M. D.

, 19 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount. DATE OF BURIAL Aug 13. 1927.

20 UNDERTAKER Geo A Farley. ADDRESS 1890 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified.

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24690

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24690

31

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., T.B. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beulah Schindeldecker

(a) RESIDENCE NO. 3027 Elliott st. St. / Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harrison Schindeldecker

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvenia

PARENTS

10 NAME OF FATHER David Mara

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Silesta Mara

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Hospital Records

(Address)

15 Filed AUG 12 1927, 19 C. HAMPSON JONES M.D. Registrar

Per RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 August 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from August 3, 19 27, to August 11, 19 27,

that I last saw her alive on August 11, 19 27,

and that death occurred, on the date stated above, at 11.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Tuberculosis yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Madden M. D.

8-11, 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. Date of Burial Aug. 15 1927

20 UNDERTAKER Lilly & Jones ADDRESS 4038 Hoffman

B.—MARRIED WOMEN, whether single, widowed or divorced, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 24691

CERTIFICATE OF DEATH.

187 E 24691

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Lancaster St. Bach's Basta 5 Ward)

2-FULL NAME Isaac Isaacs

(a) RESIDENCE NO. -1 St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 35. Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9 BIRTHPLACE (city or town).....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town).....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country)

14 Informant.....
(Address)

15 Filed.....19.....C. Harrison Jones, M. D.....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and, from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) As Above

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. Harrison Jones M. D.
(Coroner)

19 (Address) 14 3 No Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY

Date of Burial 19

20 UNDERTAKER

ADDRESS

AUG 12 1927

Deputy Commissioner Health.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 1927 RFM

Spec. 1-10-21 M&T 1500 Bks.

E 24692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161 E 24692

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3501 Garsdale Av (St.) 15-63 (Ward)

2-FULL NAME Oliver Shipley Moore, Jr.

(a) RESIDENCE NO. 3501 Garsdale Av St. 63 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Aug. 11, '27

7 AGE — Years: 0 Months: 0 Days: 0 If LESS than 1 day, hrs. or min.: 12 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Oliver S. Moore, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina

12 MAIDEN NAME OF MOTHER: Emma Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delaware

14 Informant: Mrs. Ira Miller mother

(Address): 3501 Garsdale, Md

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and ~~year~~): Aug 11, 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1927, to Aug. 11, 1927, that I last saw him alive on 8-11-, 1927, and that death occurred, on the date stated above, at 10,35 P. m.

The CAUSE OF DEATH* was as follows:

Injuries to head caused by Instrumental delivery.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Shock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emmerich Lorell M. D.

8/11, 1927 (Address) 3705 Liberty Hgts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Upper Fairmount Md — DATE OF BURIAL: Aug 12 1927

20 UNDERTAKER: Wm J Pickerdons — ADDRESS: Norfolk

AUG 12 1927 C. HAMPSON JONES, M. D.

mation should be carefully supplied. Age, she
it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it ma
TION is very important. See instructions on ba

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24693

100-001

E 24693

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. (Sinai) Hebrew Hospital 1561 Ward)

2-FULL NAME Minnie Heller

(a) RESIDENCE NO. 3307 Pomlatan Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Heller

6 DATE OF BIRTH (month, day, and year) Aug 11 - 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pikesville

(State or country)

PARENTS

10 NAME OF FATHER Julius Zschiniger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Jane Smart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John S Heller

(Address) 3307 Pomlatan Ave

15 Filed_____ 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Aug 11 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927, to Aug 11, 1927, that I last saw her alive on Aug 10, 1927, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis
Hypertension

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Coma
Bronchopneumonia
Exhaustion

(duration) .....yrs. .....mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of *

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Meyer Sherry, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Govans-Presbyterian Date of Burial Aug 13 1927

20 UNDERTAKER H. Tuckwiller Son ADDRESS N. & Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24694

74-09 E 24694

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 825 - Plum al St. 22-31 Ward)

2-FULL NAME Henry Smith

(a) RESIDENCE NO. 825 - Plum al St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Md

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE: Years 72 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. Md

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mary Dees

(Address) 825 Plum alley

15 Filed C. HAMPSON JONES, M. D. Registrar

Per _____

12 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Duration (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Jury (Coroner) M. D.

Dec 12, 1927 (Address) 1639 Bradway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prince Fredrick Cem't Date of Burial: aug 14 19

20 UNDERTAKER: Weis y Deneal ADDRESS Dun Calvert Co

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 24695

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS Ward) 6-17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E Clocker

(a) RESIDENCE NO. 2419 E. Chase St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Jan 17 1852

7 AGE 75 Years Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): md

(State or country): Hanklin Co Md

PARENTS

10 NAME OF FATHER: Baltimore

11 BIRTHPLACE OF FATHER (City or town):

(State or country): md

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): md

14 Informant: Barbara Friend

(Address)

15 Filed 1927 C. HAMILTON JONES M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-12 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-10, 1925, to 8-12, 1927, that I last saw him alive on 8-12, 1927, and that death occurred, on the date stated above, at 7 45 A. m.

The CAUSE OF DEATH* was as follows:

Hypertention Arterio-sclerosis

Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) C. Holmes Bunge M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Aug 15 1927

20 UNDERTAKER: Wolff & Turner Sons — ADDRESS: 1142 E Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24696

CERTIFICATE OF DEATH

71-002

E 24696

REGISTERED NO. 211529

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clyde Manley Senn

(a) RESIDENCE NO. Spartanburg S.C. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12 · 1924

7 AGE Years 3 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Spartanburg

(State or country) South Carolina

PARENTS

10 NAME OF FATHER Clyde Senn

11 BIRTHPLACE OF FATHER (City or town)

(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Myrtle A. Shields

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina

14 Informant

(Address)

JOHNS HOPKINS HOSPITAL

15 Filed 19 C. HERBERT JONES, M. D. Registrar

AUG 12 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 Aug 12 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 9 1927 to Aug. 12 1927

that I last saw him alive on Aug 12 19 27

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Meningitis cerebro-spinal (Epid)

(duration) — yrs. 3 mos. — da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? Spartanburg S.C.

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Yes

(Signed) C H Bagley, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Spartanburg S C	8/13/27
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Bway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 89 E 24697

1-PLACE OF DEATH Camden Station, Balto. REGISTERED NO.

City of BALTIMORE: (No. 22-30 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Lewis T. Little

(a) RESIDENCE NO. 3263 Waynesboro Ave St. Ward Waynesboro Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residenre in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
About 65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician do

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(r) Name of employer

9 BIRTHPLACE (rity or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (rity or town) Unknown

(State or country)

14 Informant Hospital records

(Address)

15 Filed C. HAMPSON JONES, M. D. 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-12-27

17 I HEREBY CERTIFY, That I attended deceased from 8-12-27, 19..., to 8-12-27, 19...,

that I last saw him alive on 8-12, 19...,

and that death occurred, on the dats stated above, at 8:55 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure (Primary)

Coronary Sclerosis (Antecedent)

Unknown (duration) ....yrs....mos....da.

CONTRIBUTORY (Secondary)

(duration) ....yrs....mos....da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test ronfirmed diagnosis?

(Signed) Lewis T. Little, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Keyser W. Va Date of Burial Aug 14 1927

20 UNDERTAKER Harry H. Witzke ADDRESS 1534 W. Lombard St

1927

tion should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 24698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 24698

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3607 Belair Rd — ST.; 26-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia A Livermon

(Residence in Baltimore: No. 3607 Belair Rd. St. 75 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, October (Month) 28 (Day), 1845 (Year)

7-AGE, 81 yrs. 9 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Peter Meldick.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A Livermon

(Address) 3607 Belair Road

15-

Filed....., 191.....

C. HAMPSON JONES, M. D.
AUG 1927
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug — 11 — 1927 (Month) (Day) (Year), 191...

17- I HEREBY CERTIFY, That I attended deceased from Dec — 1926, to Aug 11 — 1927, that I saw h~~er~~ alive on Aug 10 1927, and that death occurred, on the date stated above, at 4 p - m.

The CAUSE OF DEATH* was as follows:

1. Chronic Cardiac (Valvular) Dis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism Coma

(Duration) yrs. mos. 3 ds.

(Signed) Ford L Brune M. D.

Aug 12, 1927 (Address) 125 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Aug 15, 191..

20-UNDERTAKER Leo Rossett — ADDRESS 1142 N Gay

important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24699

CERTIFICATE OF DEATH.

31 E 24699

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1421 N. Bruce St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anastine Dorsey

(a) RESIDENCE NO. 1421 N. Bruce St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): about 1892

7 AGE: Years 37 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country): Barbados. West.

PARENTS

10 NAME OF FATHER: James Dorsey

11 BIRTHPLACE OF FATHER (city or town)

(State or country): West.

12 MAIDEN NAME OF MOTHER: Rachael Dorsey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Rachael Dorsey

(Address): 1421 N. Bruce St.

15 Filed....., 19..... C. THOMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) C. T. Jones, M. D. (Coroner)

, 19 (Address) 2 So Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Aug 13 1927

20 UNDERTAKER: Daniel Forbes ADDRESS 916 Ramsay

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24700

CERTIFICATE OF DEATH.

E 24700

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. 4-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester M. Watkins

(a) RESIDENCE NO. 12 1/2 N. Pine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 17, 1927

7 AGE: Years 3 | Months | Days 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Richard Watkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mercie Bailey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Richard Watkins

(Address) 12 1/2 N. Pine St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pleo-Colitis

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Lues of the Liver

.....(duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

(Coroner)

.....19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: aug 13 1927

20 UNDERTAKER: Daniel Carlon ADDRESS 916 Pine

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Blks.

E 24701

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24701

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles McLean

(a) RESIDENCE NO. 801 Greenmount Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. d

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-15-27

7 AGE — Years: — Months: — Days: 27 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Md

PARENTS

10 NAME OF FATHER Charles McLean

11 BIRTHPLACE OF FATHER (City or town):

(State or country) N C

12 MAIDEN NAME OF MOTHER Mary Pulley

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) N C

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 19

17 I HEREBY CERTIFY, That I attended deceased from July 20, 19 27 to Aug 12, 19 27

that I last saw him alive on Aug 12, 19 27

and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar (?)

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Prematurity

life.

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Johns Hopkins Hosp

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. Holmes M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn cemetery

Date of B... aug 1...

20 UNDERTAKER

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24702 E 24702

CERTIFICATE OF DEATH

44

1-PLACE OF DEATH 6007 Stanton Ave - Mt Washington

CITY OF BALTIMORE: (No. Old Glory Ave ST. 27-54 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Traylor

(a) RESIDENCE NO. Old Glory Ave ST. Mt Washington WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Wm Traylor

6 DATE OF BIRTH (month, day, and year) Nov. 16 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
59	5	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Thomas Curtis

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Talbot

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Lillie Gambrill
(Address) Mt Washington

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 . 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1926 to Aug 10 1927.

that I last saw her alive on Aug 10 1927.

and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Intestines - Stomache -

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of about 2 mo ago

Was there an autopsy? No

What test confirmed diagnosis? Intestinal tumors

(Signed) C. H. Bleiem M. D.

(Address) Mt Washington.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Butler Balto Co Md	Aug 13 1927

20 UNDERTAKER Franklin W. Satz — ADDRESS 709 W 33 St

CAUSE OF DEATH must be plainly written. All questions must be answered. See instructions on back of certificates.

1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 24703 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24703

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH St Joseph's Hosp. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., No 42 WARD

2-FULL NAME John M. Fetsch

(a) RESIDENCE NO. 5929 Belair Rd. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Emma L. Mrs Fetsch

6 DATE OF BIRTH (month, day, and year) Mar 15, 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
75	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work In charge of effects

(b) General nature of industry, business, or establishment in which employed (or employer) Effects Room 061

(c) Name of employer City Police Dept

9 BIRTHPLACE (city or town) (State or country) Galt Md

PARENTS

10 NAME OF FATHER John Fetsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Frahmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edgar Fetsch (Address) 5929 Belair Rd.

15 Filed 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1927, to Aug 12, 1927

that I last saw him alive on Aug 12, 1927,

and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerotic Gangrene.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) H Lawrence Fahrney, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL Aug 16 1927

20 UNDERTAKER W M Cook ADDRESS 202 E North Ave

ATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 24704 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24704

CERTIFICATE OF DEATH. X 143-0

1-PLACE OF DEATH St Josephs Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Oliver ST., 9-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edna Clarke

(a) RESIDENCE NO. 820 E. Preston ST., WARD Phila Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Clark

6 DATE OF BIRTH (month, day, and year) Dec 31, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia.

PARENTS

10 NAME OF FATHER Thomas A Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mrs E Linkinton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant William Clark (Address) 820 E Preston St

15 Filed JUN 3 1927, 19 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23, 19 27 to Aug. 11, 19 27, that I last saw her alive on Aug. 11, 19 27, and that death occurred, on the date stated above, at 1:35 p. m.

The CAUSE OF DEATH* was as follows:

Ruptured Ectopic Pregnancy.

Hemorrhage; Shock.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure. (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes. Date of June 18, 1927

Was there an autopsy? Partial.

What test confirmed diagnosis? Clinical. Autopsy.

(Signed) T. P. Thompson, M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Aug. 15 19 27

20 UNDERTAKER W. M. Cook ADDRESS 502 E. North Ave

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24705 — 24705

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 104 E. Multberry St., 4-7 Ward) — Registered No. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Brooks.

(a) Residence No. 104 E. Multberry St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 8 1927

7-AGE. Abortion yrs. mos. ds. If LESS than 1 day, 2½ hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James J. Brooks

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Lucy Thomas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

11- (Informant)
(Address)

15- Filed 192 Per RRB Registrar.

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 8, 1927

17- I HEREBY CERTIFY, That I attended deceased from Aug 8 1927 to Aug 8 1927, that I last saw h[illegible] alive on Aug 8 1927, and that death occurred, on the date stated above, at 945a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy exam.

(Signed) Dwight Reynolds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL. , 19
20-UNDERTAKER.	ADDRESS

instructions on back of certificates.

[illegible] OF MARYLAND, AUG 1 1927

Spec—12-23-21—E.B.R.S.—400 Bks.

E 24706 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24706

159-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 806 N. Madeira St. 7-12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Blumsky

(a) Residence No. 806 N. Madeira St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 8. 4. 23.

7-AGE, 4 yrs. — mos. 8 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) Paris.

(State or Country) Md.

PARENTS.

10-NAME OF FATHER Lawrence Blumsky

11-BIRTHPLACE OF FATHER (city or town) Bohemia

(State or Country)

12-MAIDEN NAME OF MOTHER Agnes Boecke

13-BIRTHPLACE OF MOTHER (city or town) Bohemia

(State or Country)

14- Mrs. Agnes Blumsky

(Informant)

(Address) 806 N. Madeira

15- Filed 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8.12.27

17- I HEREBY CERTIFY, That I attended deceased from August 4th 1927, to Aug 12th 1927,

that I last saw him alive on August 12th 1927

and that death occurred, on the date stated above, at 3-15 A. m.

The CAUSE OF DEATH* was as follows:

1 Myocardial effusion

2

3

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Congenital Heart disease

(Duration) 4 yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ?

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Paul D. Wright, M. D.

(Address) 10 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL, Aug 15 1927

20-UNDERTAKER Frank Brach & Son — ADDRESS 916 Eutaw

instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 24707

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24707

CERTIFICATE OF DEATH.

15-2379

1-PLACE OF DEATH

City of BALTIMORE: (No. 1316 N. Carey St. Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daniel C. Bradett

(a) Residence No. 1316 N. Carey St.
(Usual place of abode) St., Ward.
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 11 mos. 24 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Roberta T. Scott

6-DATE OF BIRTH (month, day and year) Aug 18 1870

7-AGE.	If LESS than 1 day,
56 yrs. 11 mos. 24 ds.	hrs. or mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Railroad Timekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Education
(c) Name of employer: Baltimore City Schools

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Rushrod Credett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary L. Creek

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Thelma F. Credett (Daughter)
(Address) 1316 N. Carey Street

15-
Filed 1927
Registrar.

APH

MEDICAL CERTIFICATE OF DEATH. 1927

16-DATE OF DEATH (month, day and year) August 11-1927

17- I HEREBY CERTIFY, That I attended deceased from October 24 1926 to Aug 11 1927 that I last saw him alive on Aug 7 1927 and that death occurred, on the date stated above, at 7.55 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Peritonitis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical findings

What test confirmed diagnosis? and Microscopic findings

(Signed) S. Bernell Sharp M. D.

. 19 (Address) 2937 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Laurel Cemetery	Aug 14, 1927
20-UNDERTAKER.	ADDRESS
Mrs. R. A. Elliott	Ashland Ave

instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24708

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 E 24708

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Thorn Lane, Granby Road ST. 15 W. 62 WARD) Clifton

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Leaf

(a) RESIDENCE No. same as above ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-11-27

7 AGE — Years — Months — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) same as above

PARENTS

10 NAME OF FATHER Lars Leaf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jonkoping, Sweden

12 MAIDEN NAME OF MOTHER Anna K. Kneis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant mother
(Address) same as above

15 Filed ... 7 ..., 19 ... Registrar

3 1927 C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-12 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-11- , 1927 , to 8-12- , 1927 ,

that I last saw him alive on 8-12- , 1927

and that death occurred, on the date stated above, at 8³⁰ p m.

The CAUSE OF DEATH* was as follows:

Atelactatic Pneumonia.

(duration) ... yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel A. Slick , M. D.

, 19 (Address) 3710 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's, Hampden — DATE OF BURIAL: Aug. 13, 1927

20 UNDERTAKER: E. Leroy Stiffler — ADDRESS: 125 E. North ave

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24709

CERTIFICATE OF DEATH.

100-001 E 24709

1-PLACE OF DEATH

City of BALTIMORE: (No. 643 Dorr St. 22-30 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lindsay Beverly

(a) RESIDENCE NO. 643 Dorr St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 [illegible], Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1900

7 AGE — Years: 27 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Labr

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va

PARENTS

10 NAME OF FATHER: John Burl

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Mary Wicks

(Address): 721 Redwood St

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 19 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Exhaustion (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) G C Bates M. D.

(Coroner)

1927 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Cemetery

Date of Burial: 8/13 1927

20 UNDERTAKER: Walter B. Spriggs

ADDRESS: 134 W. Hamburg Street

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G. CHARLTON JONES, M. D.

AUG 31 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT

Spec.—12-9-25—A Co.—200 Bks.

E 24710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 24710

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 790 N Saratoga St. 4-26 Ward)

2-FULL NAME Henry Bell

(a) RESIDENCE NO. 790 N Saratoga St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER John Bell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Alma Hall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Henderson Bell

(Address) 790 N Saratoga St

15 Filed_____, 19____ Registrar

AUG 13 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-12-1927

17

I HEREBY CERTIFY, That I attended deceased from 8-11-1927, to 8-12, 1927, that I last saw him alive on 8-11, 1927, and that death occurred, on the date stated above, at 4 05 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Acute Dilatation of Heart.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no Clinical

What test confirmed diagnosis?

(Signed) C. F. Jackson, M. D.

8/12/1927 (Address) 578 N Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Va — Date of Burial 8/14 1927

20 UNDERTAKER Samuel T. Brantley — ADDRESS 578 N Eddy

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24711

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Division ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Slaughter.

(a) RESIDENCE NO. 615 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Garrison Slaughter

6 DATE OF BIRTH (month, day, and year): 1889

7 AGE: Years 48; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Eastern Shore Md.

PARENTS

10 NAME OF FATHER: Horace Mullin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Charlotte Cade 8-10-, 19?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Amos Slaughter

(Address) 60 Eastman St.

15 Filed , 19 Registrar

C. PARKSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25 1927 to Aug 10 1927.

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical

(Signed) Leo H. Lafayette M. D.

(Address) 2281 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 8/13/27

20 UNDERTAKER: Frank T. Kneedler — ADDRESS: 1778 Riddle

CAUSE OF DEATH must be plainly written. Signature of physician must be in ink. See instructions on back of certificates.

13 1927

Spec.—8-24-14—M. & T.—2000 Bks.

E 24712 HEALTH DEPARTMENT—CITY OF BALTIMORE. 94-00 E 24712

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 Harwood St. W. Ward) 19-30

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth A Biddison

(Residence in Baltimore: No. 334 Harwood av St.; 81 yrs., 6 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb (Month) 2 (Day) 1846 (Year)

7-AGE, 81 yrs. 6 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Thos. R. Boyce

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos R Biddison

(Address) 1525 Fidelity Bldg

15-

Filed ..... 191.....

C. HAMPSON JONES, M. D. Registrar.

1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 12 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 6 1927, to Aug 12 1927, that I saw her alive on Aug 11 1927, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(Duration) yrs. mos. 12 ds.

(Signed) J. M. Lampman M. D.

Aug 13, 1927 (Address) 3409 Gallaway av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Aug 13, 1927

20-UNDERTAKER A M Tickner — ADDRESS W. N. Ave

important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24713

E 24713

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE Point View Pier St. 16-28 Ward)

2-FULL NAME Wm. F. Stehling

(a) RESIDENCE NO. 1805 Frederick Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of: Amelia Stehling

6 DATE OF BIRTH (month, day, and year): July 28th 1864

7 AGE: Years 63 Months 1 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): Baker

(c) Name of employer: -

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Wm Stehling

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Herman Stehling

(Address): 1805 Frederick Ave

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Accidental

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) G. Hamilton Jones, M. D.

(Coroner)

1/2/28 18 (Address) 1436 E. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial 8/15 1927

20 UNDERTAKER: Louis Heemann — ADDRESS 32 S. Bway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 24714

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 24714

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 212 N Gorsuch St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna. Culatta.

(a) RESIDENCE NO. 212 N Gorsuch St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 27/97

7 AGE — Years: 30 Months: 3 Days: 14

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Phillip Culatta

11 BIRTHPLACE OF FATHER (City or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Josephine Pedrie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Mrs Josephine Culatta

(Address) 212 N Gorsuch st

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 11th, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1927, to Aug 11, 1927

that I last saw h alive on Aug 11, 1927

and that death occurred, on the date stated above, at 8 Pm. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia, Cardiac Decomp.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Sovereign M. D.

, 19 (Address) 9431 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent Cemetery — Date of Burial: (Aug 15 1927)

20 UNDERTAKER: M M Conlon — ADDRESS 2238 N Smith

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24715 × 18 E 24715

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Body found in water at Colby Branch Curtis Bay

City of BALTIMORE: (No.) Ward REGISTERED NO.

2-FULL NAME James Walsh

(a) RESIDENCE NO. Aberdeen Proving Ground St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 10th 1876

7 AGE: Years 50 Months 9 Days 2 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED: (a) Trade, profession or particular kind of work: Soldier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. Govt

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Aberdeen Proving Ground

(Address) Aberdeen Md.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Autopsy and

find that said deceased came to her death (Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

Probably Fell overboard

CONTRIBUTORY (duration) yrs. mos. ds.

(Secondary)

(Signed) Thos. B. Norton M. D.

Aug 13th 1927 (Address) Curtis Bay Md.

Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional instructions.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Md. Date of Burial Aug 15 19 27

20 UNDERTAKER: T. H. Edison National Funeral Home ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 24716

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Druid Hill St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Smith

(a) RESIDENCE NO. 407 Druid Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Blk

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Smith

6 DATE OF BIRTH (month, day, and year): Dec 25/95

7 AGE: Years 32 Months 8 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Household

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): Pocomoke City Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pocomoke Md

12 MAIDEN NAME OF MOTHER: Emma Dutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pocomoke Md

14 Informant: Mary Howard

(Address): 2042 Vincent

15 Filed AUG 14 1927, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 6th, 1927, to Aug 12, 1927, that I last saw h[illegible] alive on Aug 11, 1927, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Cardiac

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustav Goldman, M. D.

, 19 (Address) 956 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pocomoke city Md.

DATE OF BURIAL: Aug 14 1927

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Presstman St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24717

CERTIFICATE OF DEATH.

154-002

E 24717

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Johns Hopkins Hospital Ward)

2-FULL NAME Gordon Lenwood Perryman

(a) RESIDENCE NO. 3571 E N Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Lenwood Perryman

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Pauline Perryman

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Lenwood Perryman

(Address) 351 Railroad Ave.

15 Filed..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:*

Premature Birth

Asphyxia Liv

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) G C Yates M. D.

(Coroner)

13/27, 19 (Address) 1436 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Balto Co Date of Burial Aug 14 27

20 UNDERTAKER Chenoweth & Son ADDRESS 3615 Gertrude Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24718

E 24718

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 249 S. Ellwood St., 1-2 Ward)

2-FULL NAME Regina B Armstrong

(a) RESIDENCE NO. 249 S. Ellwood ave St. 1-2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward A. Armstrong

6 DATE OF BIRTH (month, day, and year): May 2 1844

7 AGE — Years: 63 Months: 3 Days: 10 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEDENT

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Wilmington

(State or country): Delaware

PARENTS

10 NAME OF FATHER: Samuel Hall

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Cecil Co. Md

12 MAIDEN NAME OF MOTHER: Eliza Tyson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Cecil Co. Md.

14 Informant: Samuel H. Armstrong

(Address) 1827 E. 33rd St

15 Filed ..... 19 .....

Per R.M.K Registrar

C. HAMILTON JONES, M. D.

AUG 14 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 13 1927

17

I HEREBY CERTIFY, That I attended deceased from June 1 1926 to August 13, 1927

that I last saw h-er alive on Aug 13 1927

and that death occurred, on the date stated above, at 6.10 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) Gradual yrs. ..... mos. ..... ds.

18 Where was disease contracted Age

If not at place of death?

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Fulton M. D.

8/14, 1927 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Date of Burial: Aug 15 1927

20 UNDERTAKER: William G. Black ADDRESS: 927 N Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24719

CERTIFICATE OF DEATH.

44v E 24719

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 2513 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Columba Cremens

(a) RESIDENCE NO. Mt Hope Retreat St. Ward Catonsville

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov-21-1878

7 AGE: Years 48 Months 9 Days 22 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister of Charity

(b) General nature of indnstry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Irelands

(State or country)

PARENTS

10 NAME OF FATHER Denis Cremins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Connolly

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant: Sisters of Charity

(Address) Mt. Hope Retreat.

15 Filed ..... 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-13-27

17

I HEREBY CERTIFY, That I attended deceased from 1-21- 1927 to 8-13- , 1927,

that I last saw h[illegible] alive on 8-13 , 1927,

and that death occurred, on the date stated above, at 1.35 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Esophagus

(duration) 7 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death! at Mount Hope Retreat

Did an operation precede death! yes Date of 1-26-27

Was there an autopsy? no

What test confirmed diagnosis? clinical & Laboratory

(Signed) C. J. Knapp, M. D.

8-13, 1927 (Address) Saint Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Hope Cemetery Date of Burial Aug 15 27

20 UNDERTAKER: [illegible] ADDRESS

STEWART & MOWEN COMPANY

WILLIAM F. WARDEN, Successor

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24720

REGISTERED NO. 31 E 24720

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Schlim

(a) RESIDENCE NO. 106 N. Belnord ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ Unknown mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Schlim

6 DATE OF BIRTH (month, day, and year) Aug 21 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	35	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Bolek

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Hospital Records

(Address)

15 Filed AUG 14 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 20 19 27 to August 11, 19 27

that I last saw her alive on August 11 19 27

and that death occurred, on the date stated above, at 4.55 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Tuberculous laryngitis and enteritis (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. E. Middleton M. D.

8-12. 1927 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial Aug 14 1927

20 UNDERTAKER Fred A. Rideout ADDRESS 1031 Harford

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 24721

CERTIFICATE OF DEATH.

3 | E 24721

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 151 N. Milton ave ST., 6-10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Michelson

(a) RESIDENCE NO. 151 N Milton ave ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Michelson

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Tobachnick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Fleisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant: Nathan Michelson

(Address) 151 N Milton ave

15 Filed ..... , 19 ..... Registrar

AUG 14 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1927, to Aug 14, 1927.

that I last saw h alive on

and that death occurred, on the date stated above, at 1 09 m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericardial Effusion

(duration) 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 156 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int Carmel

DATE OF BURIAL 8/14 1927

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balt st

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

John E. Dolan.

E 24722

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24722

E 24722

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Smith Battle Gen. Hosp St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Dolan

(a) RESIDENCE NO. Rock Hall md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship builder

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Yard

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER James Dolan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ashley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant same as above
(Address) Rock Hall Md

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest, au-
(Inquest, autopsy or inquiry.)
topsy find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 2 + 3rd degree burns, accidental received on this boat. 9 days.
Contributory Nephritis
(duration) 2 mos. yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) yrs. mos. ds.

(Signed) H. T. Ruhl M. D.
Aug 14 1927 (Coroner)
, 19 (Address) 1059 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death 2 mos. yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Hall Md. Date of Burial Aug 5th 1927

20 UNDERTAKER Margaret G. Flynn ADDRESS 11 & 22 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24723

16 V. 8 24723

E 24723

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-56 Ward)

2-FULL NAME Baby Girl Rottenberg

(a) RESIDENCE NO. 2444 Shirley Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 13 1927

7 AGE	Years	Months	Days	IF LESS than 1 day 21 hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ____ 0d

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ____

(State or country) Baltimore - Md

PARENTS

10 NAME OF FATHER Joseph Rottenberg

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Washington - D C

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Baltimore - Md.

14 Informant Jos Rottenberg

(Address) 2444 Shirley Ave

15 Filed ____, 19____ Per ____ Registrar

AUG 15 1927 C. HAMILTON, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1927, to Aug 14, 1927, that I last saw h.. alive on Aug 14, 1927, and that death occurred, on the date stated above, at 11 50 a. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ____ yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Schuman, M. D.

8-14, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Hebrew Friendship	8/15/27
20 UNDERTAKER	**ADDRESS**
J. Ahrens & Co	2432 Amo

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

20 5494 E 24724 — E 24724 — X 38 — E 24724

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey Dunn (Dunn)

(a) RESIDENCE NO. 66 E St. St. Ward Hanover St

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7 27

7 AGE — Years — Months — Days: 7 1/2 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER William Dunn

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Theodosia Brown

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Records

(Address) Johns Hopkins Hospital

15 Filed ..... 19 ..... Registrar

AUG 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1927, to Aug 13, 1927, that I last saw her alive on Aug 13, 1927, and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal indigestion.

Hemorrhagic Disease of the Newly Born?

Congenital Syphilis?

(duration) ..... yrs. ..... mos. 6 da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V. E. Hamman M. D.

8/14, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Charlottesville Albemarle Co. Va. 8/16 1927

20 UNDERTAKER — ADDRESS

Wm Fraser & Son 1618 Eutaw Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24725

CERTIFICATE OF DEATH.

E 24725

E 24725

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Clay Smith

(a) RESIDENCE No. 1316 Ashland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene H. Smith

6 DATE OF BIRTH (month, day, and year) Jan 13 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	64	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C

PARENTS

10 NAME OF FATHER ? Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz. Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Irene H. Smith

(Address) 1404 Richmond Ave

15 Filed AUG 15 1927, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 4, 1927, to Aug 13, 1927, that I last saw him alive on Aug 13, 1927 and that death occurred, on the date stated above, at 10.30 A, m

The CAUSE OF DEATH* was as follows:

Hypothetic Meningitis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) Louis T. Levy, M. D.

8/19, 1927 (Address) 1 W. Balto St Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 15 1927
20 UNDERTAKER H M Moulton	ADDRESS 2338 N Mtth

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24726

E 24726.

CERTIFICATE OF DEATH.

101-001

E 24726

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (WARD)

2-FULL NAME Albert Glotkowski

(a) RESIDENCE NO. 2019 Spruce St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22 - 27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Albert Glotkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Emma Stryjewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant A. Glotkowski

(Address) 2019 Spruce St.

15 Filed , 19 RPL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13-27

17

I HEREBY CERTIFY, That I attended deceased from 8-7-27, 19 , to 8-13-27, 19 .

that I last saw h~~im~~ alive on 8-13-27, 19

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 4 days

CONTRIBUTORY (Secondary) malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emil Glotkowski M.D.

8/14/27 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL 8-15 19 27

20 UNDERTAKER F. W. Ozarowski ADDRESS 1930 Eastern

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

E 24727

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Mark. Blvd. ST. 21-29 WARD)

2-FULL NAME Charles Seitler

(a) RESIDENCE NO. 1118 Mark. Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise E. Seitler

6 DATE OF BIRTH (month, day, and year) Oct. 10-1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
61	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Anthony Seitler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Louise C. Seitler (Address) 1118 Mark. Blvd.

15 Filed ... 19 RHL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 19 27

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 19 27, to Aug 12, 19 27

that I last saw him alive on Aug 12, 19 27

and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Aug 15 19 27

20 UNDERTAKER Harry A. Witzke — ADDRESS 1531 W. Lanvale

FROM a very important See instructions on back of certificate.

AUG 15 1927 CHANDLER-JONES, M. D.

Spec.—1-12 23—MXT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24728

CERTIFICATE OF DEATH.

10-002

E 24728

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hosp. St. 24-35 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leona Moore

(a) RESIDENCE NO. 1112 Haubert St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 3 1926

7 AGE — Years: — Months: 11 — Days: 11 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Louis Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Hattie King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Mrs. Louis Moore 1126 Haubert St

15 Filed [illegible] 19[illegible] [illegible] Registrar

AUG 15 1927 HARRY JONES, M. D. R.H.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1927, to Aug 14, 1927, that I last saw her alive on Aug 14, 1927 and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

Tonsillar & Pharyngeal Diphtheria (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bac. Cult.

(Signed) Myron B. Tull, M. D.

8/14, 1927 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. — DATE OF BURIAL: Aug. 15 1927

20 UNDERTAKER: Lillye Zeiber — ADDRESS: 403 So Wolfe

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24729

1-PLACE OF DEATH

REGISTERED NO. E 24729

City of BALTIMORE: (No. Church Home & Infirmary Ward) 8-17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Martin Norwood.

(a) RESIDENCE NO. 1804 N. Wolfe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mrs Pearl F. Norwood

6 DATE OF BIRTH (month, day, and year) April 11. 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	56	4	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman - 286

(b) General nature of industry, business, or establishment in which employed (or employer) American Can Co.

(c) Name of employer Mr Anderson -

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Norwood

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER -??

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) —

14 Informant H. D. Norwood.

(Address) 1804 N Wolfe St.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

8/14/27.

17

I HEREBY CERTIFY, That I attended deceased from 7/24/27, 1927, to 8/14/27, 1927.

that I last saw h.. alive on 8/14/27, 1927.

and that death occurred, on the date stated above, at 8 40 a.m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

Gastritis Acute

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Perforated Gastric ulcer (duration) yrs. mos. 22 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of 7/28/27.

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) George B Buell, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Date of Burial Aug 17 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

OF DEATH in plain terms, so that it may be properly classified. Last Statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Joseph Gerbig

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24730 31 E 24730

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No. BALTIMORE CITY HOSPITALS Ward 22-30)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph [redacted] Gerbig

(a) RESIDENCE NO. 211 Penn St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Gerbig

6 DATE OF BIRTH (month, day, and year): Sept 15. 1837

7 AGE: 89 Years 10 Months 28 Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Joseph Gerbig

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

PARENTS

14 Informant (Address): Frederick Gerbig 211 Penn St

15 Filed AUG 15 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-13 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-27, 1926, to 8-13, 1927, that I last saw h[illegible] alive on 8-13, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc

Retropharyngeal abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted?

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) C. Hampson Jones, M. D.

(Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Aug 16 1927

20 UNDERTAKER: [illegible] — ADDRESS: 527 E Northern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24731

CERTIFICATE OF DEATH.

167-001

REGISTERED No. E 24731

1-PLACE OF DEATH

City of BALTIMORE: (No. West Baltimore St., Ward)

(If death occurred in a hospital, or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Duerbeck

(a) RESIDENCE NO. 1728 Thomas Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie V. Duerbeck

6 DATE OF BIRTH (month, day, and year) March 15, 1896

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinest

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer P. R.R.

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER George S. Duerbeck

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Matilda Stange

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Marie V. Duerbeck

(Address) 1728 Thomas Ave

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: 1 Case,

Suicide by gas.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Aug 14, 1927 (Address) 2802 Eamondale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem Date of Burial Aug 15 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24732

CERTIFICATE OF DEATH.

E 24732

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5614 Sefton Ave ST. 21-43 (WARD)

2-FULL NAME John V. Grant

(a) RESIDENCE NO. 5614 Sefton Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Eliza Purdy

6 DATE OF BIRTH (month, day, and year) May 2 - 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	90 91	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Trucking Bus

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Newyork
(State or country) Newyork

PARENTS

10 NAME OF FATHER Abner Grant

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Conn

12 MAIDEN NAME OF MOTHER Eliza Cornell

13 BIRTHPLACE OF MOTHER (city or town) New London
(State or country) Conn

14 Informant Frederick Russemala
(Address) 306 Suffolk St. Eddyford

15 Filed AUG 15 1927 19 ... Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1927

17 I HEREBY CERTIFY, That I attended deceased from ..., 19 17. to Aug 12, 19 27.
that I last saw him alive on Aug 1, 19 27
and that death occurred, on the date stated above, at 7.04 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Maurice Fogarty, M. D.

8/13 19 27 (Address) 18 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Rest Cem. Balto	Aug 16 27
20 UNDERTAKER	ADDRESS
Wm Tucker & Sons	Northern Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 24733

CERTIFICATE OF DEATH.

E 24733

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2931 W North Ave ST. (15-67 WARD)

2-FULL NAME Amelia Hagerty Ely -

(a) RESIDENCE NO. 2931 W North Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Ely

6 DATE OF BIRTH (month, day, and year) Jan 13-1850

7 AGE Years 77 Months 7 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Hagerty

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Eliz. Miller Ware

(Address) 2931 W North

15 Filed , 19 RHL, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1927

17 I HEREBY CERTIFY, That I attended deceased from May, 1924 to Aug 13, 1927.

that I last saw h alive on Aug 12, 1927.

and that death occurred, on the date stated above, at 3.45 a m.

The CAUSE OF DEATH* was as follows:

1st Acute Pneumonia in 1924 - Feeble since -

2nd Senile - Exhaustion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Loss of Sphincter Control

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. S. Parker M. D.

, 19 (Address) 3123 W Northaven

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Aug 15 1927

20 UNDERTAKER J. J. Dickson & Sons

ADDRESS Roland Ave

CAUSE OF DEATH TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24734

CERTIFICATE OF DEATH.

41 E 24734

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411 Dillon ST. 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Carrigan

(a) RESIDENCE NO. 3411 Dillon ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 25 1923

7 AGE	Years	Months	Days 17	If LESS than 1 day, hrs. or min
	3	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. J Carrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Caroline Frantum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Caroline Carrigan

(Address) 3411 Dillon St

15 Filed ..., 19... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 9, 1927, to Aug 12, 1927, that I last saw h[illegible] alive on Aug 11, 1927 and that death occurred, on the date stated above, at 8.50 a m

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) 2 yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Impacted fract [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/12/27

Was there an autopsy? No

What test confirmed diagnosis? Impacted fract. Septic Pneumonia

(Signed) [illegible] M. D.

U. S. 19[illegible] (Address) 3218 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Aug 15 1927
20 UNDERTAKER George W. Zinkler	ADDRESS 1737 E Eager St

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24735
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

46 **E 24735**
REGISTERED NO.

City of BALTIMORE: (No. So. Balto. Gen. Hospital, Ward) 26-42

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Matilda Buttermeister

(a) RESIDENCE NO. 201 Cole Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed, or Divorced. (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry a.

6 DATE OF BIRTH (month, day, and year): Dec. 31-1865

7 AGE — Years: 61 — Months: 7 — Days: 13 — IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town):
(State or country): Germany.

PARENTS
10 NAME OF FATHER: Albert Raddatz.
11 BIRTHPLACE OF FATHER (city or town):
(State or country): Germany
12 MAIDEN NAME OF MOTHER: Henrietta Gast
13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Germany

14 Informant: Louise Walmsley
(Address): 201 Cole ave.

15 Filed Aug 15, 1927, 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: August 13, 1927 -

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1927, to August 13, 1927, that I last saw her alive on August 13, 1927, and that death occurred, on the date stated above, at 8 20 A m.

The CAUSE OF DEATH* was as follows:
Uremia - General carcinomatosis

(duration) 2 yrs. mos. 0 ds.

CONTRIBUTORY (Secondary): Parotid abscess

(duration) yrs. mos. 5 ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Yes Date of Aug 12, 1927
Was there an autopsy?
What test confirmed diagnosis?

(Signed) E. Flassing, M. D.
. 19 (Address) South Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. — Date of Burial: Aug. 17 1927

20 UNDERTAKER: George W. Zickler — ADDRESS: 1737 E. Eager St.

OF DEATH in plain terms, so that it may be properly classified. Fill every blank. Make statement of OCCUPATION as very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

205-521

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-002

E 24736

CERTIFICATE OF DEATH

E 24736

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Lyon

(a) RESIDENCE NO. 524 S-13th St. Ward City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-12-26

7 AGE Years: Months: 11 Days: IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER Ferdinand

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Katie Bickstein

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19... C. HAMILTON JONES, M. D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1927, to Aug 14, 1927, that I last saw her alive on Aug 14, 1927, and that death occurred, on the date stated above, at 3 25 P. M.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home.

Did an operation precede death? No Date of None

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. W. Goldsmith, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Oak Lawn — Date of Burial 8/16 1927

20 UNDERTAKER: Louis Heimann — ADDRESS 32 S B'way

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24737
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 24737.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10 Hooper Ave ST. 21-54 WARD)

2-FULL NAME John M Daily

(a) RESIDENCE No. 10 Hooper Ave ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 9 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	0	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Spice Co
(c) Name of employer Mc Cormack Spice Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Seth Daily
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary Davidson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jesse Daily
(Address) 10 N Washington

15 Filed AUG 15 1927 C. HAMPSON, M.D. Registrar
Per R W K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13. 1927

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1927, to Aug 13, 1927, that I last saw him alive on Aug 13, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis -
Apoplexy -

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. H. Bateson, M. D.
8.14 1927 (Address) 10 N Washington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Glenc. Balto Co. Md Aug 16 19 27

20 UNDERTAKER — ADDRESS
W. C. Brooks Sparks Md

CAUSE OF DEATH is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24738

E 24738

CERTIFICATE OF DEATH.

87

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mtr Hospital 3-4 ST., WARD)

2-FULL NAME James Ernest Ware

(a) RESIDENCE NO. 1404 N Patt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ruth H. Ware

6 DATE OF BIRTH (month, day, and year): Sept 22-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	10	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: R & O R R

9 BIRTHPLACE (city or town) (State or country): Marietta Ga

PARENTS

10 NAME OF FATHER: Melvin M Ware

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sugar Valley Ga

12 MAIDEN NAME OF MOTHER: Mary F Hadaga

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Marietta Ga

14 Informant: Melvin R Ware
(Address) 313 Wyman Ave Walbrook

15 Filed AUG 15 1923 192 E. HAMPTON JONES, M. D. Registrar
By RHC

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13th 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Haemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) G C Yates, M. D.
(Coroner.)
8/15/23, 192 (Address) 1753 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Aug 15 192

20 UNDERTAKER: Robert Brooks & Son

ADDRESS

ROBERT BROOKS & SON
FUNERAL DIRECTORS & EMBALMERS

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 24739

CERTIFICATE OF DEATH.

31 L 24739

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 E Madison St. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence R. Bedford

(a) RESIDENCE NO. 1006 E Madison St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) March 2, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Bedford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Cofe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Matilda Bedford (Address) 1006 E Madison St.

15 Filed ..... 19... Per ..... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1927

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1927, to Aug 12, 1927, that I last saw him alive on Aug 10, 1927, and that death occurred, on the date stated above, at 5A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) ———

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young M. D.

8/8, 1927 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery — DATE OF BURIAL aug 15 1927

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st.

AUG 15 1927

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 24740

E 24740 CERTIFICATE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1426 McElderry St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Sampson

(a) RESIDENCE NO. 1426 McElderry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	C.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May-19-1926

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Andrew Sampson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER Jeanette Gough

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Mrs Leula Gough

(Address) 609 N. Spring St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 1927, to Aug 13, 1927, that I last saw her alive on Aug 13, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchitis acute

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Jurge R Allen, M. D.

Aug 19 1927 (Address) 505 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Asbury Cemetery Aug 15 1927

20 UNDERTAKER — ADDRESS

Mrs Chas G. Bailey 1421 Jefferson St

OF DEATH in plain terms, so that it may be properly classified. Each question must be answered if certificate is to be very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24741

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

118-00 E 24741

CITY OF SALTIMORE: (No. West Baltimore General Hospital WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Kate O'Hara

(a) RESIDENCE No. 2826 Winchester St.

(Usual place of abode)

Length of residence in city or town where death occurred 5½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE: Years 75; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Martin O'Hara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

11 Informant (Address) Mary O'Hara 2826 Winchester st.

15 Filed AUG 15 1927 16 (HAROLD JONES M. D.) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1927.

17

I HEREBY CERTIFY, That I attended deceased from July 29, 1927, to August 13, 1927, that I last saw he alive on August 13, 1927, and that death occurred, on the date stated above, at 6:30 A.m.

The CAUSE OF DEATH* was as follows:

Acute intestinal obstruction

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 29, 1927

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas D. Cohen M. D.

, 19 (Address) West Baltimore Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cath. Cem. DATE OF BURIAL: Aug 16 1927

20 UNDERTAKER: Jos. J. Merrason ADDRESS: 164 N. Eutaw

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24742

CERTIFICATE OF DEATH.

188-023

E 24742
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Agnes Hosp (St.) 90-69 (Ward)

2-FULL NAME Earl Phillipps

(a) RESIDENCE NO. 448 Furrow St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 27 1921

7 AGE — Years: 6 Months: 4 Days: 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ch

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baexo

(State or country)

PARENTS

10 NAME OF FATHER Floyd M Phillipps

11 BIRTHPLACE OF FATHER (city or town) Baexo

(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Otter

13 BIRTHPLACE OF MOTHER (city or town) Baexo

(State or country)

14 Informant Floyd M. Phillipps

(Address) 448 Furrow St

15 Filed..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained Investigation (Inquest, autopsy or inquiry) find that said deceased came to Life death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock due to Fract of R. Femur - & Comminuted Compound fract of R. Tibia & Fibula - Struck by Auto Truck - Lived 3 hours

and 15 1927 (Signed) Thos. B. Horton M. D. (Coroner)

(Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Date of Burial Aug 15 1927

20 UNDERTAKER George L. Schwartz ADDRESS 2104 Fleet St.

OF DEATH in plain terms, so (that it may be properly very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24743

1-PLACE OF DEATH

129

REGISTERED NO. E 24743

City of BALTIMORE: (No. 4012 Hillsdale Road. 28-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Foster,

(a) RESIDENCE NO. 4012 Hillsdale Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John T. Foster,

6 DATE OF BIRTH (month, day, and year) February 10. 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	70	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER John Mc Gregor,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Scotland.

12 MAIDEN NAME OF MOTHER Nancy Irwin,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant John T. Foster

(Address) 4012 Hillsdale Road

15 Filed AUG 15 1927, 19 H. M. NEWMAN-LOWE, M.D. Registrar

Per R.W.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) AUG 14 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1927, to Aug 14, 1927,

that I last saw h~~e~~s alive on Aug 13, 1927,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation – Pulmonary Oedema

duration ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Aortic Stenosis – Chronic Interstitial Nephritis about

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) J. Mahon, M. D.

, 19 (Address) 1300 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL London Park — Date of Burial AUG 17 1927 19

20 UNDERTAKER Geo W Little — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24744

CERTIFICATE OF DEATH

38 E 24744

1-PLACE OF DEATH

City of BALTIMORE: (No. 112 Welcome St. Ward) REGISTERED NO.

2-FULL NAME Richard Boyd

(a) RESIDENCE NO. 112 Welcome St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 28 yrs. 5 mos. 16 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Boyd

6 DATE OF BIRTH (month, day, and year): Feb 28-1899

7 AGE: Years 28 Months 5 Days 15 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Transfer

(b) General nature of industry, business, or establishment in which employed (or employer): Business

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John E Boyd

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eleanor Mason

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Maryland

14 Informant: Nelson Ward

(Address): 610 S. Broadway

15 Filed AUG 15 1927, 19 Per CHARLTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/13 1927

17 I HEREBY CERTIFY, That I attended deceased from 1/10, 1926, to 8/13, 1927, that I last saw him alive on 8/11, 1927, and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Aortic aneurysm (Probably Luetic)

(duration) yrs. Chron mos. ds.

CONTRIBUTORY (Secondary): Hemorrhage Sudden death

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann neg

(Signed) Dan Drucker M. D.

8/13, 1927 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

Date of Burial: Aug 17 1927

20 UNDERTAKER: Sm Brown & Son

ADDRESS: Baltimore

tion should be carefully supplied. Exact statement of OCCUPATION is ay be properly classified. OF DEATH in plain terms, so that it may be ck of certificates. very important. See instructions on back o

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24745

CERTIFICATE OF DEATH.

12-50 129

REGISTERED NO. E 24745

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 E. Twenty Second St., 12 WARD)

2-FULL NAME Frederick H. Bruck

(a) RESIDENCE NO. 206 E. Twenty Second ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret R. Bruck

6 DATE OF BIRTH (month, day, and year) Jan. 13, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lambert Automobile Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry F. Bruck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —— Hinkleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Margaret R. Bruck

(Address) 206 E. Twenty Second St.

15 Filed AUG 15 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/13/1927

17

I HEREBY CERTIFY, That I attended deceased from 8/12, 1927, to 8/13, 1927, that I last saw h alive on 8/13, 1927, and that death occurred, on the date stated above, at 3-a m.

The CAUSE OF DEATH* was as follows:

Myocarditis -

Cerebral Hemorrhage -

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas J. Kirke M. D.

, 19 (Address) 532 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 8/15, 1927

20 UNDERTAKER E. Leroy Stiffler

ADDRESS 125 E. North Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24746 — 129 — E 24746

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. University Hospital St., 12-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irnes Martin Curie

(a) RESIDENCE NO. 2119 Maryland ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 3 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah M. Jones

6 DATE OF BIRTH (month, day, and year) 3-2-1852

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min..
	75	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Supply store in the County.

(c) Name of employer

9 BIRTHPLACE (city or town) Smiths Falls

(State or country) Ontario, Canada

PARENTS

10 NAME OF FATHER ~~James~~ Martin Curie

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret Williamson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Berwickshire, Scotland.

14 Informant Mrs Martha W. C. Fall

(Address) Tunaby N. J.

15 Filed ____, 19 — Registrar

AUG 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to Aug 14, 1927,

that I last saw h. alive on 8-14, 1927,

and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Anaemia

(duration) ____ yrs. ____ mos. 20 ds.

CONTRIBUTORY (Secondary) Pernicious exhaustion

Lungs-Pulmonary Edema.

(duration) ____ yrs. ____ mos. 4 ds.

18 Where was disease contracted if not at place of death? Same.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Al Daints Cemetery — Aug 16 1927

20 UNDERTAKER — ADDRESS

J. F. Coline & Sons Reisterstown Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 24747 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24747

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1517 N. Callington ave. Registered No.

City of BALTIMORE: (No. 1517 North Callington ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Hans

(a) Residence No. 1517 North Callington ave St., 8 Ward.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widow Widowed, ~~or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced, ~~Husband~~ of (or) WIFE of Henry Hans

6-DATE OF BIRTH (month, day and year) Aug 29 1844

7-AGE. 82 yrs. 11 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of Industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, George Blumeaur

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Mary Magnus
(Address) 1517 N. Callington ave

15- Filed Aug 12 1927 C. HAMILTON JONES, M. D. Registrar.
By [illegible]

instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 11, 1927

17- I HEREBY CERTIFY, That I attended deceased from Feb 28 1927 to Aug 11 1927
that I last saw her alive on Aug 11 1927
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
Unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. M. Biedermann M. D.
Aug 12 1927 (Address) 540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 15 1927
20-UNDERTAKER.	ADDRESS
F. C. Benning & Son	1726 E. Lafayette ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24748

CERTIFICATE OF DEATH.

E 24748

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun and Fayette ST., 9-47 WARD)

2-FULL NAME Miss Anna Welanicus

(a) RESIDENCE NO. 628 Fair Oak Ave ST., WARD Glenburnie Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18 1879

7 AGE — Years: 48 — Months: — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Hungary

PARENTS

10 NAME OF FATHER: Anton Welancsics

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungary

12 MAIDEN NAME OF MOTHER: Mary Toth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary

14 Informant: Frank J. Orban
(Address) 3810 Eddington Ave

15 Filed AUG 15 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1927, to Aug 14, 1927, that I last saw her alive on Aug 14, 1927, and that death occurred, on the date stated above, at 3 00 A m.

The CAUSE OF DEATH* was as follows:

Cancer of the ovary with cancer of the peritoneum.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ascites - as result of above. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Previous operation.

(Signed) Louis N. Tollin, M. D.

19 (Address) Franklin Square Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Aug 16 1927

20 UNDERTAKER: George L. Smith — ADDRESS: 1532 Hollins

CAUSE OF DEATH to be filled in plain terms, so that it may be understood by a layman. See instructions on back of certificates.
TION is very important.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24749
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

170 E 24749
REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Cushing Tarbett

(a) RESIDENCE NO. 249 Schenley Ave. St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: White
5 Single, Married, Widowed, or Divorced (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Deceased

6 DATE OF BIRTH (month, day, and year): July 20. 1865

7 AGE: Years 62 Months — Days 25 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED: Retired ??
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Wm D. Barnett
11 BIRTHPLACE OF FATHER (city or town) D. C.
(State or country)
12 MAIDEN NAME OF MOTHER Janet M. Cushing
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Katherine Barnett
(Address) 249 Schenley Road

16 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13-27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or enquiry.)
thereon and from the evidence obtained by said jury
(Inquest, autopsy or enquiry.)
find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol shot wound in temple
2½ hrs (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

June 13 (Signed) W J Peter M. D.
(Coroner)
, 19 27 (Address) 1639 Linn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Date of Burial June 17 1927

20 UNDERTAKER John O. Waterfall & Sons ADDRESS 1420 Eutaw Pl.

OF DEATH If plan (this, so that it may be properly very important. See instructions on back of certificate.

Spec.—1-12 23—M&T—500 Blks.

E 24750 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24750

CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1322 Weldon St. 13-57 (WARD)

2-FULL NAME Infant of Herman & Mary Sheffer (Premature)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1322 Weldon ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State) Laura

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: mal

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Aug 13 1927

7 AGE: Years | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Herman Sheffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Mary O'Hara

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Mary Sheffer 13 M. Weldon

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to Aug 13, 1927, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows: Premature Infant

(duration) yrs. mos 4 hrs

CONTRIBUTORY (Secondary): Malformation Premature

(duration) yrs. mos. 4 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Wm F Kelly, M. D.

Aug 13, 1927 (Address) 4 Govans Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- St Marys Hampden — DATE OF BURIAL

UNDERTAKER Clemmer & Son — ADDRESS 2195 Eastern Ave

TION IS VERY IMPORTANT. See instruction on back of certificate

C. BAR... JONES, M.

AUG 17 1927

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24751

CERTIFICATE OF DEATH.

129 E 24751

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Ensor St. ST.; 9-16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Byrnes

(Residence in Baltimore: No. 1605 Ensor St. St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, February 19, 1852 (Month) (Day) (Year)

7-AGE, 75 yrs. 5 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Wm O'Keeffe

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Welsch

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephen L. Byrnes

(Address) 1605 Ensor St

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 11, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 1927, to Aug 11 1927, that I saw her alive on Aug 10 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Cancer

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis

arteriosclerosis (Duration) 10 yrs. mos. ds.

(Signed) William E. Fraught M. D.

8/14/27, 1927. (Address) 2225 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, St Vincents Cemetery

DATE OF BURIAL, 8/16, 1927

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

important. See instructions on back of certificate.

C. HAMILTON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24752

CERTIFICATE OF DEATH

101-001 ✓ E 24752

1-PLACE OF DEATH Md. General Hospital

REGISTERED NO.

City of BALTIMORE: (No. 36-42 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert W. Bradyhouse

(a) RESIDENCE NO. 37 E. Forrestview Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 0 mos. 29 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 53 yrs. 0 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. A. W. Bradyhouse

6 DATE OF BIRTH (month, day, and year): July 14 1874

7 AGE — Years: 53 Months: 0 Days: 29 (28)

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Thomas Bradyhouse

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Balto

12 MAIDEN NAME OF MOTHER: Matilda Hunt

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto

14 Informant: Hosp. Record

(Address)

15 Filed AUG 15 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 12, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 8-8-27, 19 ..... to 8-12, 19 27, that I last saw h[im] alive on 8-12, 19 27, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

4 yrs

(duratinn) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted: Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Evidence

(Signed) Thos. Bradyhouse, M. D.

. 19 (Address) 37 E. Forrestview Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial: Aug. 16 1927

20 UNDERTAKER: Geo. J. Rutter ADDRESS 1235 Hanford Av

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24753

E 24753

CERTIFICATE OF DEATH

44

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 840 S Bond St., St. 35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Pabst.

(a) RESIDENCE NO. 840 S Bond St., St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Louis Pabst

6 DATE OF BIRTH (month, day, and year) March 30, 1858

7 AGE	Years	Months	Days
	69	4	15

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER George Repp

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Troeger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Henry Pabst

(Address) 835 S Bond St.

15 Filed ..... 19 ..... Registrar

AUG 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14 1927

17

I HEREBY CERTIFY, That I attended deceased from ....., 1926, to 8/13, 1927.

that I last saw h[illegible] alive on ....., 1927.

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer on Cancerous Stomach

(duration) 6 yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Krudow M. D.

(Address) 918 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Trinity Cemetery	8/17 19/27

20 UNDERTAKER Harry A. Doty, Jr. ADDRESS 1534 N. Londo[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24754

CERTIFICATE OF DEATH.

23 E 24754

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. J H Hospital, St. ____ 5-8 Ward)

2-FULL NAME Patrick Burris

(a) RESIDENCE NO 609 Central Ave St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) March 17th 1924

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ____

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Raymus Brown

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) ____

12 MAIDEN NAME OF MOTHER Bertha Burris

13 BIRTHPLACE OF MOTHER (city or town) Agusta

(State or country) Ga.

14 Informant Annie Woodridge

(Address) 609 N. Central Ave

15 Filed ____ 19 ____ ____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Tumor.

(duration) 2 yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) G C Hales M. D.

(Coroner)

19 (Address) 1143 E Fay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial 8/16 19 27

20 UNDERTAKER Brown & Wright ADDRESS 1218 McElderry St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24755 113 E 24755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 531 E Fitting St. 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren A Kirby

(a) RESIDENCE NO. 531 E Fitting St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): B. 31. 26

7 AGE: Years | Months 8 7 | Days 15 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Arthur Kirby

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: Eliz Howard

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Arthur Kirby

(Address) 531 E Fitting St

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8.15 1927

17 I HEREBY CERTIFY, That I attended deceased from 8.14, 1927, to 8.15, 1927, that I last saw h[illegible] alive on 8.14, 1927, and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) .....yrs. .....mos. 3 ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. Dunlington, M. D.

, 19 (Address) 1026 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leader Hill Date of Burial: Jun 16 1927

20 UNDERTAKER: J F McCully ADDRESS: 128 E Fort Ave

OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 24756

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

E 24756

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 531 E Fitting St. 24-33 Ward)

2-FULL NAME Carroll Kirby

(a) RESIDENCE NO. 531 E Fitting St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (Write the word)
M	White	Sing

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12.31.26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Arthur Kirby

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Eliz Howard

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Arthur Kirby

(Address) 531 E Fitting St

15 Filed _____, 19__ _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 August 14

17 I HEREBY CERTIFY, That I attended deceased from 8.14, 1927, to 8.14, 1927, that I last saw h[illegible] alive on 8.14, 1927, and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Uremic Enteritis

(duration) ____ yrs. ____ mos. 5 ds.

CONTRIBUTORY (Secondary) Anuria

(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L F Burlington, M. D.

, 19 (Address) 1026 Hunt av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — Date of Burial Aug 15 1927

20 UNDERTAKER J H McCully — ADDRESS 128 E Hoffman

OF DEATH in plain terms, so that it may be of certificates. very important. See instructions on back of c

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24757

CERTIFICATE OF DEATH

129 E 24757

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPT St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Wallace

(a) RESIDENCE NO. 1407 E Eden St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1901

7 AGE: Years 26 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Calvert Co

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Clark

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) JOHNS HOPKINS HOSPT

15 Filed AUG 13 1927, 19 P. M. BALTIMORE, MD. Registrar RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Aug 12 - 1927

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927, to Aug 12, 1927, that I last saw her alive on Aug 12, 1927, and that death occurred, on the date stated above, at 6:30P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, Uremia

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? B. Chem

(Signed) Raymond Wing, M. D.

19 (Address) Johns Hopkins Hosp, Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

Date of Burial: Aug. 19

20 UNDERTAKER: Jerome J. Burke

ADDRESS: 1403 E. Pratt St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24758

CERTIFICATE OF DEATH.

129 E 24758

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1404 Cairo ST. 19-27 WARD)

2-FULL NAME Isaac Galloway

(a) RESIDENCE NO. 1404 Cairo St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mall

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Galloway

6 DATE OF BIRTH (month, day, and year): May 13 1887

7 AGE: Years 40 — Months 2 3 — Days 13 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Al Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER: Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Robt Galloway (Address): 416 n. Arlington Ave

15 Filed 19 Registrar

C. HAMPTON JONES, M.D.

OCT 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 7th 1927, to Aug 13 1927.

that I last saw him alive on Aug 13 1927.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos ds

CONTRIBUTORY (Secondary): not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry F Brown M. D.

Aug 13 1927 (Address) 916 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: Aug 16th 1927

20 UNDERTAKER: A. Jones — ADDRESS: 11 S. Gilmor

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24759

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24759

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 9-45 WARD)

2-FULL NAME Ella Green

(a) RESIDENCE NO. Odenton, A.A. County. Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Nonresident ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	0	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gertrude Isaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Gertrude Green

(Address) Odenton, Md

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 11, 1927, to Aug 14, 1927, that I last saw her alive on Aug 14, 1927 and that death occurred, on the date stated above, at 5 00 a m.

The CAUSE OF DEATH* was as follows:

Pertussis.

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

Aug 9/15 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catacdonia Cemt

DATE OF BURIAL Aug. 15 1927

20 UNDERTAKER C. H. Parker

ADDRESS 92 West Annapolis Md.

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24760

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Ilgenfritz

(a) RESIDENCE NO. 439 N. Chilton St. Ward City

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Ilgenfritz

6 DATE OF BIRTH (month, day, and year) Oct 13. 1870

7 AGE	Years	Months	Days
	56	10	1

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Joiner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hodall & Co

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Jacob Ilgenfritz

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country) Not Known

14 Informant Friends.

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.. Registrar

AUG 15 1927 C. HILTON LEWIS, M. D.

RRA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1927, to Aug 14, 1927, that I last saw him alive on Aug 14, 1927, and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

Aortic Stenosis & Insufficiency

Mitral .

Myocardial Failure (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 da.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) Raymond Wing. M. D.

. 19 (Address) Johns Hopkins Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — Date of Burial Aug 17 1927

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS 1710 Fleet St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24761 E 24761

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 38 N 11th St., (WARD) 34)

REGISTERED NO. 16106

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Formatura Birth of Edward & Martha Schmitzer

(a) RESIDENCE NO. 38 N 11th St., WARD 2

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) S

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day 10 hrs or min

Abstracted from Formatura

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Edward V. Schmitzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Martha Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Edward V. Schmitzer

(Address) 38 N 11th St

15 Filed ..... 19 .....

Per 1611 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/13, 1927, to 8/17, 1927,

that I last saw h[illegible] alive on 8/15 1927

and that death occurred, on the date stated above, at 8-15 A.m.

The CAUSE OF DEATH* was as follows:

Formatura

Epzoik

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Stomatitis Exfoliativa

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Wright Snyder M. D.

Smith, 192 (Address) 3326 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

TION IS VERY important. See instructions on reverse side.

[illegible] C. HAMILTON JONES, M. D. [illegible] MARYLAND

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24762

CERTIFICATE OF DEATH.

161-09

E 24762

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Ward) 15-65

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Roache.

(a) RESIDENCE NO. 3820 Norfolk Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1hr & 43minutes How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Infant.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Aug. 13 1927

7 AGE: Years | Months | Days | IF LESS than 1 day ... hrs. or 43 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Church Home & Infirmary Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John D. Thomas

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Nelson.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant: Wyanoke Totterdale

(Address) Church Home & Infirmary

15 Filed ....., 19 .....

Registrar

1645

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug 13, 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1927, to Aug 13, 1927, that I last saw him alive on Aug 13, 1927, and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

Premature (six and one half months)

(duration) 1 hrs & 43 minutes.

CONTRIBUTORY (Secondary)

hydramnios (duration) ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wyanoke Totterdale M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19

20 UNDERTAKER | ADDRESS

OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 24763

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (1425 St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Pleasants

(a) RESIDENCE NO. 620 W. Saratoga st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years 58 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deck hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Pleasants

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Grace James

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

1617 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 14 19 27 to August 9 19 27

that I last saw him alive on August 9 19 27

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

Pulmonary tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Madden, M. D.

8-10- 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

tion should be carefully supplied. Age should be stated EXACTLY. If unknown, approximate. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

28

AUG 16 1927

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24764

CERTIFICATE OF DEATH.

66 E 24764

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. Pronounced dead at St. Mercy Hosp Ward

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sam King

(a) RESIDENCE NO. 729 S. Front St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about 50	—			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Central Police Sta
(Address) Balto

15 Filed....., 19.....
1618 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 — 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
and that said deceased came to death
(autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Body found at Calvert & Pratt Sts —

(duration) mos. ds.

(Signed) Thos. B. Horton M. D.
Coroner

Aug 20 1927 (Address) Curtis Bay Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

OF DEATH in plain terms, so that it may be understood. very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24765

CERTIFICATE OF DEATH

161-801

E 24765

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 151 W. Hamburg St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee

(a) RESIDENCE NO. 151 W. Hamburg St. 23 Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 8/31/27

7 AGE — Years — Months 1 Day. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) ..... (State or country) md

PARENTS

10 NAME OF FATHER Wm. Wiggins

11 BIRTHPLACE OF FATHER (City or town) ..... (State or country) Va.

12 MAIDEN NAME OF MOTHER Delsa Lee

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) md.

14 Informant Delsa Lee (Address) 151 W Hamburg St

15 Filed ..... 19 .....

Registrar

1619

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/27

17 I HEREBY CERTIFY, That I attended deceased from 8/1/27, 19 27, to 8/4/27, 19 27, that I last saw h— alive on 8/4/27, 19 27, and that death occurred, on the date stated above, at 6.30A m.

The CAUSE OF DEATH* was as follows:

Premature Labor

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Prolapse Umbilical Cord

Extracted Pelvis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? no.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thos Bayley, M. D.

8/5/27, 19 (Address) 708 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24766

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24766

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. St. 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Breeden

(a) RESIDENCE NO. 534 S 13th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Aug-8-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	-	-	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Breeden

11 BIRTHPLACE OF FATHER (city or town) Charlottesville (State or country) Virginia

12 MAIDEN NAME OF MOTHER Teethus Haney

13 BIRTHPLACE OF MOTHER (city or town) Charlottesville (State or country) Virginia

14 Informant Corpenham (Address) JOHNS HOPKINS HOSPITAL

15 Filed Aug 15 1927 C. HANSON JONES, M. D. Registrar

1624

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-10-1927

17 I HEREBY CERTIFY, That I attended deceased from Aug-8-, 1927, to Aug-10, 1927, that I last saw h im alive on Aug-10-1927, and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Corpenham, M. D.

Aug 11, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—1-12-23—M&T—500 Blks.

E 24767

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 24767

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 N. Curley ST., 7-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philomina Georges

(a) RESIDENCE NO. 617 N. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Frank Georges

6 DATE OF BIRTH (month, day, and year) Sept. 2 - 1851

7 AGE Years 75 Months 11 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Nicholas Acker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Mrs. Jas. Georges (Address) 617 N. Curley St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/1927

17 I HEREBY CERTIFY, That I attended deceased from aug 1, 1927, to aug 14, 1927, that I last saw her alive on aug 11-1927 and that death occurred, on the date stated above, at 5 30 a m

The CAUSE OF DEATH* was as follows:

Uraemia (chr. Brights) arterial Hypertension & Sclerosis angina pectoris & Bronchitis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam of urine etc.

(Signed) Louis F. Krumrein, M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 8/16 1927

20 UNDERTAKER J. A. Moran ADDRESS 3009 E Baltimore

C. HAMPSON JONES, M. D.

TION is very important See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 24768 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24768

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 Maugold St., 71-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Keilholtz

(a) RESIDENCE NO. 830 Maugold ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alvirter Keilholtz

6 DATE OF BIRTH (month, day, and year) Sept 17, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	10	27/28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer) B & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Keilholtz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Wigley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alvirter Keilholtz (Address) 830 Maugold St

15 Filed AUG 15 1927 19 Per Rose C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1926, to Aug 14, 1927, that I last saw him alive on Aug 14, 1927 and that death occurred, on the date stated above, at 4209 m

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach metastasis to Liver

(duration) yrs. 19 mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy. Tests

(Signed) Fred Y. Kyper, M. D.

, 19 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Aug 17 1927

20 UNDERTAKER Wm. Mus. John W. Teufel & Son ADDRESS 801 N. Fayette

TION is very important. See instructions on back

E 24769

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24769

(PLACE OF DEATH Forest ave New Nopel ave. Hillsdale City Limits

REGISTERED No. C

CITY OF BALTIMORE (No. Hillsdale Baltimore N S. 25-61 ST.: 61 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Jane Pittler.

(Residence in Baltimore: No. Forest ave. New Nopel ave. - Hillsdale, Md. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: August (Month) 10 (Day), 1927 (Year)

7 AGE: ..... yrs. ..... mos. 5 ds. If LESS than 1 day, ...hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Hillsdale, Baltimore Md.

PARENTS

10 NAME OF FATHER: George J. Pittler.

11 BIRTHPLACE OF FATHER (State or country): Baltimore City.

12 MAIDEN NAME OF MOTHER: Ella Knorr

13 BIRTHPLACE OF MOTHER (State or country): Baltimore City

14 I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father Geo J. Pittler.

(Address) Forest ave New Nopel ave -

15. C. HAMPSON JONES, M. D.

Filed ..... 191 ..... Per ..... REGISTRAR

15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 13 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1927, to Aug 13 1927.

that I saw h... alive on Aug 13, 1927.

and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Grossly Developed -
In Tra Cranial Hemorrhage.

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) Septicemia.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Donnan M. D.

..... 191 (Address) Sinai Hospital Baltimore.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: New Cathedral Cemety. DATE OF BURIAL: Aug 16, 1927

20 UNDERTAKER: Joo Joerdens & Son ADDRESS: 217 S. Paca St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 24770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24770

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3401 Park Heights Ave ST. | 5-58 WARD)

REGISTERED NO. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Filippo Maggio

(a) RESIDENCE No. 3401 Park Heights Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 35 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of Caterina Maggio

6 DATE OF BIRTH (month, day, and year) Feb 17th 1856

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Thomas Maggio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Fatta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank Maggio

(Address) 3401 Park Heights Ave.

15 Filed AUG 15 1927, 19 ... C. HAMPSON JONES, M. D. By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from 1-1-, 1926, to 8-14-, 1927, that I last saw h[illegible] alive on 8-14-, 1927, and that death occurred, on the date stated above, at 9-45 P. m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis & hypertension - Aortoritis - Specific.

Angina pectoris.

(duration) 2 yrs. mos dys

CONTRIBUTORY (Secondary) Cardiac Thrombosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Demarco M. D.

8-15-1927 (Address) 1604 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mere Cathedral

DATE OF BURIAL Aug 17th 1927

20 UNDERTAKER Frank V. Petrone

ADDRESS 2818 E. Baltimore St

TION is very important. See instructions on ba

E 24771

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24771

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3612 Sycamore St. St., 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ... William F. Chrest

(Residence in Baltimore: No. 3612 Sycamore St. 40 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, Divorced (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Unknown (Month) (Day) (Year)

7-AGE. 65 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Street Paver
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. George Albert Chrest

11-BIRTHPLACE OF FATHER. (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ... Roy L. Chrest

(Address) ... 3800 Boarman Ave.

15-

Filed ... 192 ... C. HAMPSON JONES, M. D.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August (Month) 14 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Inquest, and (autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John H. Morrison M. D.

(Coroner)

8/15 1927 (Address) 3532 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Mt. Olivet Hanover, Pa. Aug. 17 1927

20-UNDERTAKER. Horace H. Burgee ADDRESS 3631 Falls Rd

is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24772 ✓ E 24772

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 S. Monroe ST. ~~Wood~~ 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Oliver Dunkerly

(a) RESIDENCE No. 519 S. Monroe St ST. 28th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Dunkerly

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) B.&.O.R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Richard Dunkerly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Virginia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mary J. Dunkerly (Address) 519 S. Monroe St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14, 19 27

17 I HEREBY CERTIFY, That I attended deceased from August 5, 19 27, to August 13, 19 27, that I last saw h im alive on August 13, 19 27 and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetis Melitis ?

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. Revolucion, M. D.

8/15/27 (Address) 24 N Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Aug 16th 1927

20 UNDERTAKER F. B. Wippert ADDRESS 1855 W. Baltimore St

5 1927 C. HAWLEY JONES, M. D.

THIS is very important. See instructions on back of this certificate.

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 24773

E 24773

CERTIFICATE OF DEATH.

Registered No. 27-54 179

1-PLACE OF DEATH

City of BALTIMORE: (No. 131 North Ave - Mt Washington St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frances Baughman

(a) Residence No. 131 North Ave - Mt Washington St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widow Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Baughman

6-DATE OF BIRTH (month, day and year) July 8 1837

7-AGE. 90 yrs. 6 mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town). Northumberland Pa.
(State or Country).

PARENTS.

10-NAME OF FATHER, W. C. Short

11-BIRTHPLACE OF FATHER (city or town) ..... Pa.
(State or Country).

12-MAIDEN NAME OF MOTHER, Mary Hinton

13-BIRTHPLACE OF MOTHER (city or town) .....
(State or Country). unknown

14- (Informant) Dr Baughman

(Address) 13 Littlestown Pike

15-

Filed ..... 192 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 14 1927

17- I HEREBY CERTIFY, That I attended deceased from June 15, 1927 to Aug 14 1927.

that I last saw her alive on Aug 13, 1927.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Intersticial Nephritis

(Duration) 4 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Personal observation.

(Signed) Wm Conrad Boyle, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Park Cemetery — DATE OF BURIAL. aug 16 1927

20-UNDERTAKER. Chas. G. Black — ADDRESS 742 W. Fayette

Instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24774

CERTIFICATE OF DEATH.

90 E 24774

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3407 Cedardale Rd. St. Ashburton 15-62 Ward)

2-FULL NAME John Lewis

(a) RESIDENCE NO. 3407 Cedardale Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lewis

6 DATE OF BIRTH (month, day, and year) Jan 10 1855

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	72	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Copper Smelter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Swansea

(State or country) Wales

PARENTS

10 NAME OF FATHER Thomas Lewis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Wales

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Wales

14 Informant Mrs Albert W. Rosebery

(Address) 3407 Cedardale Rd

15 Filed ....., 19 ..... Registrar

AUG 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 2 27 to Aug 13, 1927, that I last saw h.. alive on Aug 13, 1927 and that death occurred, on the date stated above, at 5-30 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. A. Shoob, M. D.

19 (Address) 806 N Gilmor

Aug 14-27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery Date of Burial Aug 16 1927

20 UNDERTAKER William C. Black ADDRESS 927 N Broadway

DO NOT WRITE in this space. Please write very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24775

CERTIFICATE OF DEATH.

84

E 24775

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 E Randall ST. 24-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Joseph Clishian

(a) RESIDENCE NO. 506 E Randall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Englehardt

6 DATE OF BIRTH (month, day, and year) June 1st 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Locomotive R.R. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) R.R. 73

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Littleton W. Va.

PARENTS

10 NAME OF FATHER Anthony Clishian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Rafferty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William T. Clishian

(Address) 506 E Randall St

15 Filed AUG 16 1927 19 Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12 1927

17

I HEREBY CERTIFY, That I attended deceased from August 7th 1927 to August 12 1927.

that I last saw him alive on August 12 1927.

and that death occurred, on the date stated above, at 11 45 P.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral tumor

(duration) — yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy Exam

(Signed) J. W. Cliff M. D.

8/13 1927 (Address) 922 n Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL aug 16 1927

20 UNDERTAKER Margt. G. Flynn

ADDRESS 1632 Light St

IMPORTANT—See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24776

CERTIFICATE OF DEATH

74-001

E 24776

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1320 Linden Ave. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Daily

(a) RESIDENCE NO. 1320 Linden Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long In U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 25-1855

7 AGE: Years 72 Months 1 Days 20 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: Ephraim Daily

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Julia Hering

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Florence H. Primrose

(Address) Tudor Hall Apts

15 Filed C. H. [illegible] Registrar

Per R.M.K.

AUG 16 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug. 15. 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6 –, 1927, to Aug. 15 –, 1927.

that I last saw her alive on Aug, 1927.

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia. cause Hemorrhage in brain

Abdominalis

(duration) – yrs. – mos. 10 ds.

CONTRIBUTORY (Secondary) Coma

(duration) – yrs. – mos. 7 ds.

18 Where was disease contracted ——

If not at place of death?

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

8/16/1927 (Address) 1223 N. Carolina St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Aug 17 1927

20 UNDERTAKER: John O. Middendorf & Sons — ADDRESS: 1301 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spgs.—7-18-27—Co.—200 Bks.

E 24777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

9 ✓ E 24777

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2 E. Montgomery St. W-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton T. Railey Jr

(a) RESIDENCE NO. 2 E Montgomery St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 26 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 20 1927

7 AGE Years Months 3 Days 25 26

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Milton T Railey Sr

11 BIRTHPLACE OF FATHER (City or town) Solomons Island
(State or country)

12 MAIDEN NAME OF MOTHER Fannie A. Beall

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C.
(State or country)

14 Informant Milton T Railey
(Address) 2 E Montgomery st

15 Filed AUG 16 1927, 19 (HOWARD JONES, M. D.) Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to Aug 13, 1927, that I last saw h alive on Aug 13 1927, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. L. Seabury, M. D.

Aug 16, 1927 (Address) 636 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Solomons Island — Date of Burial: Aug 17 1927

20 UNDERTAKER: John F. Deering — ADDRESS: 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. [illegible]-2[illegible] A-C-7-2[illegible] Blk.

E 24778

205-6/78

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24778

CERTIFICATE OF DEATH

159-203

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Baker

(a) RESIDENCE NO. 910 S. Caroline St. Ward Alley

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	-	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work -0-

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md -

(State or country) Baltimore,

PARENTS

10 NAME OF FATHER Sam Baker

11 BIRTHPLACE OF FATHER (City or town) Va -

(State or country)

12 MAIDEN NAME OF MOTHER Anna Wilson

13 BIRTHPLACE OF MOTHER (city or town) Md -

(State or country)

14 Informant Friends -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to Aug 14, 1927, that I last saw him alive on Aug 14, 1927, and that death occurred, on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of Diaphragm with Ectasia

(duration) five hrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? yes

(Signed) [illegible], M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer Cem	Aug 17 1927
20 UNDERTAKER George W. Zinkler	ADDRESS 1737 E. Eager St.

OF DEATH in plain terms, so that it may be properly classified. Each statement of cause of certificates. very important. See instructions on back

Spec.—1-12 23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24779

CERTIFICATE OF DEATH.

129 E 24779

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 N. Milton Ave WARD 8-16)

2-FULL NAME Anna J. Burns

(a) RESIDENCE NO. 1625 N. Milton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward J. Burns

6 DATE OF BIRTH (month, day, and year): Sept 25 1870

7 AGE: Years 57 Months 10 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Jennie Burns (Address) 1625 N. Milton Ave

15 Filed , 19 Per Registrar

TION is very important. See instructions on back of Certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14, 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-27, 1927 to Aug 14, 1927 that I last saw h[illegible] alive on Aug 13, 1927 and that death occurred on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation Nephritis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Fred Burnett, M. D.

6/6 1927 (Address) 1100 N Patt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 17, 1927

20 UNDERTAKER: Emmet W. Conklin — ADDRESS: 924 E Eager St.

JUN 15 1927 C. HAMILTON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24780

CERTIFICATE OF DEATH.

E 24780
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 453 W 24th ST. 17-51 WARD)

2-FULL NAME Bridget Kelly

(a) RESIDENCE NO. 453 W 24th ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J Kelly

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Fahey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J Kelly
(Address) 453 W 24th St

15 Filed 19 Aug Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1927

17

I HEREBY CERTIFY, That I attended deceased from July 27, 1927, to Aug 13, 1927.

that I last saw her alive on Aug 13, 1927

and that death occurred, on the date stated above, at 5. P. m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Hypertension Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & Hist.

(Signed) R B Norment M. D.

8/16, 1927 (Address) 3643 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gethsemane Cem	8/17 1927

20 UNDERTAKER Joseph A Finley ADDRESS Fulton & Fayette

"TION is very important See instructions on back of certificate.

C. J. PEARCE, M. D.

E 24781

E 24781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

26 478 9

X 60-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

City of BALTIMORE: (No.) St., 1-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ewald Schramm

(a) RESIDENCE NO. 768 Jasper St. St. Ward Columbus

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 mos ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 - 1907

7 AGE Years: 20 Months: 2 Days: 6

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio -

(State or country)

PARENTS

10 NAME OF FATHER Wm Schramm

11 BIRTHPLACE OF FATHER (City or town) Ohio

(State or country)

12 MAIDEN NAME OF MOTHER Martha Eppler

13 BIRTHPLACE OF MOTHER (city or town) Ohio

(State or country)

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 , Registrar

AUG 16 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1927, to Aug. 16, 1927, that I last saw her alive on Aug. 16, 1927, and that death occurred, on the date stated above, at 1.25 a. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic goitre

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes. Date of Aug. 12.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) E. E. Jones, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Columbus Ohio — Date of Burial: Aug 16 1927

20 UNDERTAKER: William Cook — ADDRESS: 501 E Main St

OF DEATH in plain terms. Do not use abbreviations. Name of cause (a), (b), and (c) may be the same. Primary cause is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 188-003 E 24782

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hotel St. 12-5-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Haywood Smith

(a) RESIDENCE NO. 2501 Oakley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Richmond

6 DATE OF BIRTH (month, day, and year): about 1899

7 AGE — Years: 28 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Goucher College

9 BIRTHPLACE (city or town):

(State or country) Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant:

(Address) 2501 Oakley St.

15 Filed ..... 19..... Registrar

Per ..... M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Aug 7, 19 27 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial Aug 16 19 27

20 UNDERTAKER: Samuel H Kemsley ADDRESS 538 W Baltimore

Cut on dotted line and paste on piece of paper before filling in. Certificate. Be sure to fill in every item. Space for each item is limited. Be brief but write plainly. Every item is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

E 24783 — 90 — E 24783

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. [illegible] St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Harris

(a) RESIDENCE NO. 522 So Caroline St. Ward 4

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Harris

6 DATE OF BIRTH (month, day, and year) 6/12 1890

7 AGE 37 Years 2 Months 3 Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Unable to ascertain

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country) Unknown

14 Informant Josh Robin Minnie Harris

(Address) 522 S Caroline St

15 Filed ..... 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-15 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1927, to 8-15, 1927, that I last saw him alive on 8-15, 1927, and that death occurred, on the date stated above, at 6 00 A. m.

The CAUSE OF DEATH* was as follows:

Hypertention –
Hemiplegia right
Ch. Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Objective findings

(Signed) C. Holmes Boyd M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — Date of Burial 8 17 1927

20 UNDERTAKER George J Ruth — ADDRESS 1735 Harford Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24784

CERTIFICATE OF DEATH.

REGISTERED NO. E 24784

1-PLACE OF DEATH

City of BALTIMORE: (No. Federal Reserv Bank. Redwood St., 70-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore G. Groth

(a) RESIDENCE NO. 2545-N. Fairmount Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Amelia Groth

6 DATE OF BIRTH (month, day, and year) Jan 17 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	39	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Federal Reserve Bank

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Henry Groth

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Amelia Groth

(Address) 2545-W. Fairmount Ave

15 Filed ..... 19 .....

Per .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 13/ 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. Grad.

Dont Know — Acute Endocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

Aug 16 , 19 27 (Address) 1659 Bradley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial 8/17/27

20 UNDERTAKER Geo Lenhardt & Son ADDRESS 528 N. Eutaw St

* very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 24785

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 E 24785

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 133 W Hill St 22-31 Ward)

2-FULL NAME Jno Elliott

(a) RESIDENCE NO. 133 W Hill St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 - 1904

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	23	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. C.

(State or country)

PARENTS

10 NAME OF FATHER Will Elliott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Sarah Smith

13 BIRTHPLACE OF MOTHER (city or town) C

(State or country) Va.

14 Informant Mariah Elliott

(Address) 133 W Hill

15 Filed 19 Aug 14 1923 Registrar

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 - 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal tract obstruction.

Fall from doorstep in Cellarway

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Aug 15, 19 23 (Signed) W J Riley M. D.

(Coroner)

(Address) 1033 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lenoir N. C. Date of Burial Aug. 17 1923

20 UNDERTAKER C. W. Brown & Son ADDRESS 108 W. Monument St

P RR to S.R.

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 24786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24786

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4611 Maine Ave 28-64 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thos Hieatzman

(a) RESIDENCE NO. 4611 Maine Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lora B. Hieatzman

6 DATE OF BIRTH (month, day, and year): May 29-1872

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
55	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: meat Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Mathais Hieatzman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Margarita. Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Lora B. Hieatzman

(Address): 4611 Maine Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 13 1927

17 I HEREBY CERTIFY, That I attended deceased from 1917, 19 ..., to Aug 13, 19 27.

that I last saw h[illegible] alive on Aug 13, 19 27

and that death occurred, on the date stated above, at 9.15 m.

The CAUSE OF DEATH* was as follows:

Cardio - Nephritis

CONTRIBUTORY (Secondary) (duration) 10 yrs. mos ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 2 ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Love, M. D.

Aug 15, 19 27 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk Cem

DATE OF BURIAL: Aug 17 1927

20 UNDERTAKER: H. J. Dickson, Jones

ADDRESS: Fulton Ave

TION is very important. See instructions on back of certificate.

AUG 15 1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24787

CERTIFICATE OF DEATH.

57 E 24787

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 W. Barney ST. 23-32 WARD)

2-FULL NAME Adalaide Kell

(a) RESIDENCE NO. 2 W. Barney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Kell

6 DATE OF BIRTH (month, day, and year): Feb 16 1871

7 AGE — Years: 56 — Months: 6 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Alexandria (State or country) Va

PARENTS

10 NAME OF FATHER: Richd Roland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER: Amanda Knowles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address): John W. Kell 2 W. Barney st

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): aug 15 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to aug 15, 1927, that I last saw h alive on aug 15, 1927, and that death occurred, on the date stated above, at 3.00 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Glucose

(Signed) R H Campbell M. D.

(Address) 1644 Gwynns

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alexandria Va

DATE OF BURIAL: aug 17 1927

20 UNDERTAKER: Fred. A. Kraus

ADDRESS: 703 Hanover

Cor.—12-9-25—A Co.—200 Bks.

E 24788

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 E 24788

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 24-16 Ward)

2-FULL NAME George E. Jones

(a) RESIDENCE NO. 115 N. Hilton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara S. Jones

6 DATE OF BIRTH (month, day, and year) February 20, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Park Cop

(b) General nature of industry, business, or establishment in which employed (or employer) Policeman

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas R. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Keller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Clara S. Jones

(Address) 115 N. Hilton St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain
1 Hour 15 Min
Suicide Shot Self in head

(Duration) yrs. mos. ds.

(Secondary) (Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

Aug 16 1927 (Coroner) (Address) Cedar & Curtis Aves

*State the Disease Causing Death, or if Resulting from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Visitants, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial 8/15/27

20 UNDERTAKER Harold Cook ADDRESS 1803 W. Baltimore St

Cor. Dec 4

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

24789

CERTIFICATE OF DEATH.

185 E 24789

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Maryland St. 4-26 Ward)

2-FULL NAME Ford. Miller

(a) RESIDENCE NO. 770 N. Lex St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 17/1870

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Enameling Co

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles W. Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant John J. Jung,

(Address) 1000 E. Chase St.

15 Filed_____ 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Fall from Window-

Fracture of Skull

(duration) 1 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Shock

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) G E Radcliffe, M. D.

(Coroner)

Aug 16 1927 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. Date of Burial Aug 18 1927.

20 UNDERTAKER Mr & Mrs. John W. Templeton ADDRESS 811 W Fayette

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24790

CERTIFICATE OF DEATH.

131 E 24790

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 Bradley ST. 17-26 WARD)

2-FULL NAME Arthur & the Washington

(a) RESIDENCE NO. 710 Bradley ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 32 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Washington

6 DATE OF BIRTH (month, day, and year) Sept 30 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	31	10	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Alice Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fredericksburg Va

14 Informant Raymond Stoffan (friend)
(Address) 32 E Diamond St

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 18 1921 to Aug 15 1927 that I last saw him alive on Aug 14 1927 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Abscess of Kidney
(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Empyema
(duration) 0 yrs. 0 mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 1925

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R B Kenyon M. D.
8/15 1927 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 17 1927
20 UNDERTAKER David Easton?	ADDRESS Balto

CAUSE OF DEATH to be filled in plainly with ink or indelible pencil. TION is very important. See instructions on back of certificates.

C. HAMILTON JOHNS, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24791

CERTIFICATE OF DEATH.

X,188-002 E 24791

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mmo Hospital 4-30 St., ____ Ward)

2-FULL NAME Harry Williams

(a) RESIDENCE NO. Kellys Station Md. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mgt Williams

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Dick Knox

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Dick Knox

12 MAIDEN NAME OF MOTHER Dick Knox

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dick Knox

14 Informant Mgt Williams

(Address) Kellys Station

15 Filed _____ 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an M. Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Ac Car Acc Fracture of Skull

(duration) ___ yrs. ___ mos. Instt ds.

CONTRIBUTORY (Secondary) Shock

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) G C Stader M. D.

(Coroner)

10/27 (Address) 143 W 31 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lambels Run Date of Burial Aug 17 1927

20 UNDERTAKER Daniel Ensor ADDRESS 916 Eu Av

Cut of certificate. See instructions on back of very important.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24792

CERTIFICATE OF DEATH.

101-001

E 24792

1-PLACE OF DEATH

City of BALTIMORE: (No. 1341 Carlton Ave St. 24-35 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Stilz Jr. 22 Taylor

(a) RESIDENCE NO. 1341 Carlton Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 15 1927

7 AGE (7 mos) Years Months 7 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Steve S

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Wallace

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mrs Frank Stilz

(Address) 1341 Carlton Ave

15 Filed ....., 19..... C. HAMILTON JONES, M. D.

Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.)

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Lobar (Right)

3 weeks (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

(Coroner)

Aug 16, 1927 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem Date of Burial Aug 17 1927

20 UNDERTAKER: John M Weber ADDRESS 1803 Bo... Ave

150

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24793

CERTIFICATE OF DEATH.

185 ✓ E 24793

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospital St. 22-30 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maryanna. Kaliszak (or Jaszcz)

(a) RESIDENCE NO. 2008 Monmonier Court St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4 1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Grusczynski

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Mr. Stanislaus . Kaliszak(son)

(Address) 2008 Monmonier Court

15 Filed_____, 19____ Per_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Fall (acc.)
Fracture of Skull
(duration) yrs. mos. 2 hr.
Shock.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. 2 hr.

(Signed) W. C. Hamson Jones M. D.
(Coroner)
, 19 (Address) 143 W. Pray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Date of Burial Aug 18 19 27

20 UNDERTAKER Petra M Weber ADDRESS 803 Bond St

Of the utmost importance. See instructions on back of certificate. very important.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24794

CERTIFICATE OF DEATH.

74-001

E 24794

1-PLACE OF DEATH

City of BALTIMORE: (No. 1636 Clarkson St. 23-32 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph L. Brunner

(a) RESIDENCE NO. 1836 Clarkson St. 23 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude Gruber

6 DATE OF BIRTH (month, day, and year): June 6 1893

7 AGE: Years 34 | Months 2 | Days 14 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tin metal

(b) General nature of industry, business, or establishment in which employed (or employer): worker

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Balto

PARENTS

10 NAME OF FATHER: Rev. M. Brunner

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Gruber

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto Md

14 Informant: Gertrude L. Brunner

(Address): 1836 Clarkson

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): aug 15 19 27

17

I HEREBY CERTIFY, That I attended deceased from June 11 1927, to aug 15 1927,

that I last saw h[illegible] alive on aug 15 1927,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary): Cardiac sclerosis

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? N.

Did an operation precede death? N. Date of.....

Was there an autopsy? N.

What test confirmed diagnosis?

(Signed) H. B. Hunter, M. D.

, 19 (Address) 43 Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Balto Date of Burial 8/18 19 27

20 UNDERTAKER: J. F. Fahey & Sons ADDRESS 31 Light St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24795

CERTIFICATE OF DEATH.

5 ✓ E 24795

1-PLACE OF DEATH

City of BALTIMORE: (No. 2628 Eyola Southway St., 15-58 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny Sachs

(a) RESIDENCE NO. 2628 Eyola Southway Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Jacob Sachs

6 DATE OF BIRTH (month, day, and year): Jan 15th 1863

7 AGE: Years 64; Months 7; Days____; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)_____

(c) Name of employer_____

9 BIRTHPLACE (city or town)_____

(State or country) Russia

PARENTS

10 NAME OF FATHER Meyer Coplan

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie —

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Russia

14 Informant Mrs Bernstein

(Address) 2628 Eyola Southway

15 Filed_____ 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mell.

(duration) ____ yrs. 1 mos. ____ ds.

CONTRIBUTORY (Secondary) Thrombosis

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) G. E. Gates M. D.

(Coroner)

7-27 19 (Address) 143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Shalom Cem Date of Burial 8/17 19 27

20 UNDERTAKER: Jack Levers ADDRESS 1439 E Baltimore

AUG 17 1927 H. JONES, M.D.

of certificate.

very important. See instructions on back of cer

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24796

CERTIFICATE OF DEATH.

117 E 24796

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Gerber

(a) RESIDENCE NO. 3412 Springdale Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Blanche Gerber

6 DATE OF BIRTH (month, day, and year) (7)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectionary Store

(b) General nature of industry, business, or establishment in which employed (or employer) Employer

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER A Gerber

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) —

14 Informant Blanche Gerber

(Address) 3412 Springdale Ave

15 Filed....., 19.....

Per H. H. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug. 17-1927.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1927, to Aug. 17, 1927, that I last saw him alive on Aug. 17, 1927, and that death occurred, on the date stated above, at 12:10 a.m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) 1. Paralytic Ileus. 2. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? yes Date of Aug. 13-27.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. Schaman, M. D.

Aug 17, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave Date of Burial 8/17 1927

20 UNDERTAKER Jack Levis ADDRESS 1439 E Balt

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 24797

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 N. Wolfe St ST. 64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Flax

(a) RESIDENCE NO. 214 N Wolfe St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bettie Flax

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 80 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Baker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Isaac Flax

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Etta —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Bettie Flax

(Address): 214 N Wolfe St

15 Filed , 19 RPK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/11/27 19

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1927, to Aug 16, 1927, that I last saw him alive on Aug 16, 1927, and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Pulmonary oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Signs + symptoms

(Signed) W. H. Hedrick, M. D.

, 19 (Address) 2225 Fenwick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mekrem Hebrew Rem

DATE OF BURIAL: 8/17 1927

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 Eutaw St

TION is very important. See instructions on reverse side.

Cor.—12-9-26—A Co.—200 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

107-003

E 24798

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 24798

REGISTERED NO.

City of BALTIMORE: (No. 206 N. Parcon St. 14-27 Ward)

2-FULL NAME Addie Taylor

(a) RESIDENCE NO. 1573 W. Saratoga St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Cold

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Taylor

6 DATE OF BIRTH (month, day, and year): Nov. 18 = 1886

7 AGE — Years: 40 — Months: 8 — Days: 27 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country) =

PARENTS

10 NAME OF FATHER: Peter Canada

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va =

12 MAIDEN NAME OF MOTHER: Sallie Smothers

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va =

14 Informant: Henry Canada

(Address) 1520 W. Saratoga St

15 Filed ..... 19 .....

Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lungs

Duration yrs. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

(Signed) Thos. B. Norton M. D.

Aug 16 1927 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (Use other side of this space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemtry — Date of Burial 8/17 1927.

20 UNDERTAKER: Walter B. Spriggs — ADDRESS 1394 W. Lombard

Cor. 1927 C. HAMILTON JONES, M. D.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24799

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 24799

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2730 N. Charles ST., 12-51 WARD)

2-FULL NAME Wilbur F. Thompson

(a) RESIDENCE NO. 2730 N. Charles ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah S. Thompson

6 DATE OF BIRTH (month, day, and year) July 18, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
83	✓		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) Drug Store

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas E. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Gamprill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Zelma Thompson

(Address) 2730 N. Charles St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 16 1927

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 12 ... to August 16 19 27

that I last saw him alive on August 15 19 27

and that death occurred, on the date stated above, at 12.15 A M.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam

(Signed) Geo. M. Gipple M. D.

8/16, 19 27 (Address) 2430 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Aug 17 1927

20 UNDERTAKER W. M. Cook — ADDRESS 502 E. North Ave.

AUG 17 1927 C. H. [illegible] JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24800
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74-001

E 24800
REGISTERED NO.

City of BALTIMORE: (No. 613 Harvey St. 24-33 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Schneider

(a) RESIDENCE NO. 613 Harvey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Md

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Schneider

6 DATE OF BIRTH (month, day, and year): Dec 24 1863

7 AGE: Years 63 Months 7 Days 25 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town): Balto
(State or country)

10 NAME OF FATHER: Mrs. Mittelmann

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Germany

14 Informant: M E Seeman
(Address): 613 Harvey

15 Filed....., 19..... Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 16 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration

CONTRIBUTORY (Secondary)

Duration

(Signed) (Coroner) M. D.

Aug 16, 19 27 (Address) 1657 Lowden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Date of Burial: Aug 18 1927

20 UNDERTAKER: J. Cook ADDRESS: 500 E Monument

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24801

CERTIFICATE OF DEATH

E 24801

REGISTERED NO.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. 4-30 St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Jane Caufield

(a) RESIDENCE NO. Dundalk md St. Ward Not Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Caufield

6 DATE OF BIRTH (month, day, and year) Nov 13, 1867

7 AGE: Years 59 Months 9 Days 3 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Penn Station PA (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER — Watson

11 BIRTHPLACE OF FATHER (City or town) (State or country) England

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Caufield Dundalk (Address) 24 Highway road

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1927, to Aug 16, 1927, that I last saw her alive on Aug 16, 1927 and that death occurred, on the date stated above, at 2.10 a.m.

The CAUSE OF DEATH* was as follows:

Oedema of lungs,

(Myocarditis with Oedema of lungs)

following Cholecystitis

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

Acute Cholecystitis (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Aug 8 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P. S. Anderson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Lawn Cem

Date of Burial Aug 18

20 [redacted] TAKER John Valerio

ADDRESS 200 Aisquith

OF DEATH in plain words, do not use abbreviations. Omit no item, as the absence of any one may be very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24802

CERTIFICATE OF DEATH.

E 24802

REGISTERED NO. 90

1-PLACE OF DEATH 508 N. Central Ave

CITY OF BALTIMORE: (No. 508 N. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michala Perriance Lewis

(a) RESIDENCE NO. 508 N. Central Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Lewis

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 60 Months unknown. Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Joseph Perriance

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Louisa Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Lillie Edwards 508 N. Central Ave.

15 Filed ..... 19..... Registrar: Riese

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-15 1927

17

I HEREBY CERTIFY, That I attended deceased from 8-14 1927 to 8-15 1927.

that I last saw h[illegible] alive on 8-15 1927.

and that death occurred, on the date stated above, at 2 50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion
Myocarditis
Acute Cardiac dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W. B. Butler, M. D.

19..... (Address) 425 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashurn Cemetery DATE OF BURIAL: Aug. 18 1927

20 UNDERTAKER: Chas. H. Coleman ADDRESS: 410 N. Caroline

TION is very important. See instructions on Back of Certificate.

HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24803

CERTIFICATE OF DEATH.

46 E 24803

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Myrtle Ave. St. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Rinn

(a) RESIDENCE NO. 1111 Myrtle Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 11-1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Patrick Rinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Daniel Rinn

(Address) 1111 Myrtle Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 2 - , 1927, to Aug 15 , 1927,

that I last saw h alive on Aug 15 , 1927

and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Inoperable)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 1-1926

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) Paul Brown, M. D.

Aug 15, 1927 (Address) 1837 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Aug 17 1927

20 UNDERTAKER H. C. Brauning, Sons

ADDRESS 514 N. Howard St

C. CHAMPION JONES, M.D.

AUG 17 1927

Spec.—12 6 25—A Co.—200 Bks.

E 24804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 74002

E 24804

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No. _____ St. 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Frances Lohman

(a) RESIDENCE NO. Stevenson Run Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph F. Lohman

6 DATE OF BIRTH (month, day, and year): May 1 1872

7 AGE: Years 55 | Months 3 | Days 15 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Indnstry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Jacob Shriver

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country): Unknown

14 Informant: Joseph F. Lohman

(Address): Stevenson Run Md

15 Filed ..... 19 ..... Registrar

AUG 17 1927 C. HAMPSON JONES M.D.

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-16 1927

17

I HEREBY CERTIFY, That I attended deceased from 8-1, 1927, to 8-16, 1927,

that I last saw her alive on 8-16, 1927,

and that death occurred, on the date stated above, at 4.9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Terminal Broncho Pneumonia (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? clinical tests

(Signed) A. J. Knapp, M. D.

8-16, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Josephs Cemetery Date of Burial Aug 19 1927

20 UNDERTAKER: Fredk Lassahn & Son ADDRESS: Fullerton

very important. See instructions on back of certificates.

Cer.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24805

CERTIFICATE OF DEATH.

90 E 24805

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2314 Division St., 13-59 Ward)

2-FULL NAME Annie L. Chase

(a) RESIDENCE NO. 2314 Division St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 4, 1887

7 AGE: Years 40 Months 6 Days 10

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Dr.

(c) Name of employer

9 BIRTHPLACE (city or town): _____

(State or country): Va.

PARENTS

10 NAME OF FATHER: Levi Kellum

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Rachel Rugg

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Va.

14 Informant: Susie Wise

(Address): 2314 Division St.

15 Filed _____ 19____ Per _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 14, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ___ yrs. 3 mos. ___ ds.

CONTRIBUTORY (Secondary) no other known cause

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) S. P. Hennessy M. D.

(Coroner)

Aug 14 1927 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — Date of Burial: Aug. 17, 27

20 UNDERTAKER: Jno. M. Johnson — ADDRESS 1234 Ellwood St.

Very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 24806

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24806

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

City of BALTIMORE: (No. 407 Locust ave. Overlea St., Ward 24-42) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Bokman

(a) Residence No. 407 Locust ave. Overlea Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Howard E. Bokman

6-DATE OF BIRTH (month, day and year) June 4th 1880

7-AGE, 47 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md. Maryland

PARENTS.

10-NAME OF FATHER, John L. Kirby

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto. Maryland

12-MAIDEN NAME OF MOTHER, Laura Dorsey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Howard Co. Maryland

14- (Informant) Howard E. Bokman (Address) 407 Locust ave. Overlea

15- Filed AUG 17 1927 19.. C. HAMILTON JONES, M. D. Registrar. Per K.K.K

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 15 1927

17- I HEREBY CERTIFY, That I attended deceased from Aug 25th 1926 to Aug 15 1927 that I last saw h.e alive on Aug 15 01 1927 and that death occurred, on the date stated above, at .....m. The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. mos. ds

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 1 ds

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Lab

(Signed) Edw. W. Benson M. D

Aug 15 1927 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Aug 18 1927
20-UNDERTAKER.	ADDRESS
Fredk Lasdon & Sons	Fullerton

Instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

24807

HEALTH DEPARTMENT—CITY OF BALTIMORE

531 W Baltimore 90 E 24807

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Eudokim Bichko or Dakim

REGISTERED NO.

City of BALTIMORE: (No. Aug 15/27 St. 27-30 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Audokim Bychko or Dakim

(a) RESIDENCE NO. 531 W Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Car Repairer — R.R.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Audo Bychke or Dakim

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Orra Lisos

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Andrew Padnuk
(Address) 608 S. Charles

15 Filed 1927 C. HERSON JONES, M. D.
Per H.H.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) August 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) L. Paley M. D.
(Coroner)
Aug 17, 19
(Address) 639 Cathedral

*(State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Russian Indepedet Cem. Aug. 18. 1927

20 UNDERTAKER — ADDRESS
John Grebliauckas J.G. 423 S Paca St.

very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24808

CERTIFICATE OF DEATH.

9 E 24808

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 S Tucker ST. 15-22 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roger Dorsey Jr.

(a) RESIDENCE NO. 1340 Strickel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of + +

6 DATE OF BIRTH (month, day, and year) Nov 29 1926

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
+	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER Roger Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Roger Dorsey (Address) 1340 Strickel St

15 Filed C. 19 CLAYTON JONES, M. D. AUG 17 1927 R & K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14. 1927. to Aug 15. 1927 that I last saw him alive on Aug 14. 1927. and that death occurred, on the date stated above, at 1.30 A m. + The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Whooping-Cough

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E. Clark M. D.

Aug 17 1927 (Address) 3214 Piedmont Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL Aug 19 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 1303 Eastern St

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24809

CERTIFICATE OF DEATH.

31 E 24809
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 458 Pinkney Ave ST., 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B. Heatherlick

(a) RESIDENCE NO. 458 Pinkney Ave ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Heatherlick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Pinkney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Christina E Heatherlick
(Address) Catonsville Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to Aug 16, 1927, that I last saw h.e alive on Mar 16, 1927 and that death occurred, on the date stated above, at 6 P m

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. W. Pearce, M. D.

(Address) Preston & Pinkney 46.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Aug 19 1927
20 UNDERTAKER	ADDRESS
J. Cook	507 E Baltimore

Spec.—1-12-23—M&T—500 Bks.

24810

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 E 24810

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Greenway Apt.

CITY OF BALTIMORE: (No. 345 E. Charles ST. 12-49 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dollie Glorvina Fulton.

(a) RESIDENCE NO. Greenway Apt. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 10 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 24. 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	72	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. Carroll Fulton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia

12 MAIDEN NAME OF MOTHER Kimberly.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs. Lessie A. Jones 42 Roland Court. Roland Pk.

15 Filed AUG 17 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1926, to Aug. 16 1927.

that I last saw h[illegible] alive on Aug 15 1927

and that death occurred, on the date stated above, at 7.35 A M

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Marcia Lazenby, M. D.

8/16. 1927 (Address) 1844 E. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Mount Cem	Aug 18 1927

20 UNDERTAKER Henry A. Jenkins Sons & McCurdy

ADDRESS Richmond Va.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24811

CERTIFICATE OF DEATH

E 24811

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 620 N. Ellwin St., Ward 47)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia Gerhardt

(a) RESIDENCE NO. 620 N. Ellwin St. Ward

(Usual place of abode) Mc Kewin Ave (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 4 1854

7 AGE — Years: 73 Months: 2 Days: 11

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER Geo Gerhardt

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Mrs Phillip Chait

(Address) 620 N. Ellwin St

15 Filed ..... 19 ..... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to July 15, 1927, that I last saw her alive on July 15, 1927, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wilfred C. [illegible] M. D.

, 19 (Address) 620 N. Ellwin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — Date of Burial: Aug 18 1927

20 UNDERTAKER: Hiss Fields — ADDRESS: 1200 N. Fremont

See instructions on back of certificates.

AUG 1 1927 BALTIMORE MD.

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 24812

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24812

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 724 Carrollton Ave North

CITY OF BALTIMORE: No. ST. WARD 16-25

REGISTERED NO. 21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Mary Cassard

(a) RESIDENCE No. 724 N. Carrollton Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Nov 14 1903

7 AGE — Years: 23 Months: 9 Days: 15 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Public School

(c) Name of employer: Balto. City Balto City Md

9 BIRTHPLACE (city or town) (State or country): Balto City Md

PARENTS

10 NAME OF FATHER: Walter G. Cassard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va (Virginia)

12 MAIDEN NAME OF MOTHER: Malvina C Fillmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Walter G. Cassard

(Address) 724 N. Carrollton ave

15 Filed AUG 17 1927 Registrar R M C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): AUG 15 1927

17 I HEREBY CERTIFY, That I attended deceased from June 28 1927 to Aug 15 1927

that I last saw her alive on Aug 15 1927

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum positive

(Signed) Samuel I. Daggett M. D.

(Address) 1015 Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 8/19/1927

20 UNDERTAKER: Geo. Weber & Son

ADDRESS: 2503 Edmondson ave

THIS IS very IMPORTANT. See instructions on other side

AUG 17 1927 HEALTH DEPT. BALTIMORE MD

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

24813

CERTIFICATE OF DEATH.

E 24813 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 717 E. Fort Ave St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Montgomery

(a) RESIDENCE NO. 717 E. Fort Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robt L. Montgomery

6 DATE OF BIRTH (month, day, and year): Sept 9-1887

7 AGE: Years 39 Months 11 Days 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Wm Woodley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Robt L. Montgomery

(Address) 717 E. Fort Ave

15 Filed ....., 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Aug 14

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to Aug 14, 1927, that I last saw h.. alive on Aug 14, 1927, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell, M. D.

Aug 15 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial: 8/17/1927

20 UNDERTAKER: C. D. Fanning & Son — ADDRESS: 1460 Battery Ave.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24814

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 Clifton Ave ST. 15-60 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Lehrer

(a) RESIDENCE NO. 2208 Clifton Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca Lehrer

6 DATE OF BIRTH (month, day, and year): 3-15-1894

7 AGE: Years 33 Months 5 Days 2

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Rebecca Lehrer (Address) 2208 Clifton Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/17 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15 1927, to Aug 17 1927.

That I last saw him alive on Aug 17 1927

and that death occurred, on the date stated above, at 9:45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 1927

Was there an autopsy? yes

What test confirmed diagnosis? Microscopic

(Signed) Wm Barlow M. D.

8/17 1927 (Address) 710 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rebecca Randall

DATE OF BURIAL: 8/19 1927

20 UNDERTAKER: Jack Levin 1439 Pratt

ADDRESS

HON IS VERY important. Be accurate.

C. HAMILTON, M. D.

AUG 17 1927

Spec.—1-12-23—M&T—500 Blks.

E 24815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

73 E 24815

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 N Appleton ST. 15-21 WARD)

2-FULL NAME Floribel Deems Robinson

(a) RESIDENCE NO. 1723 N Appleton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. Walter Robinson

6 DATE OF BIRTH (month, day, and year) Feb. 14 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry Deems.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mollie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant Mr. E. Walter Robinson
(Address) 1723 N Appleton St.

15 Filed ....., 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Aug 16, 1927, that I last saw her alive on Aug 16, 1927, and that death occurred, on the date stated above, at 5.45 a m.

The CAUSE OF DEATH* was as follows:

Ascending Spinal Myelitis

(duration) 14 yrs. mos ds.

CONTRIBUTORY (Secondary) Progressive Asthenia

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

, 19 (Address) 27 W Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Aug. 18 1927

20 UNDERTAKER Wm Hackney Sons ADDRESS North Ave

C. HAMPTON JONES, M.D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24816 ✓ 97-901 E 24816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1320 N. Carey St. 15-23 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lennia Young

(a) RESIDENCE NO. 1320 N. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown.

6 DATE OF BIRTH (month, day, and year): about 1867.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): [illegible]

(State or country): East

PARENTS

10 NAME OF FATHER: Wm Edwards

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Louise Edwards

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: John Young

(Address): 132 N. Carey St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 15, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and from the jury find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no other findings

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Pearson M. D.

(Coroner)

Aug 8, 19 27 (Address) 1802 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Date of Burial Aug 8 1927

20 UNDERTAKER: Thos. W. Chase & Son ADDRESS 1100 Mosher

Very important. See instructions on back of certificate.

1927 C. JAMES JONES M.D.

Spec.-7-17-26—A Co.—200 Blks.

E 24817

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24817

CERTIFICATE OF DEATH

37-801

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto. City Hospitals St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Smith

(a) RESIDENCE NO. 648 Cider alley St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1920

7 AGE: Years 7 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Jesse Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mabel Cornish

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Hospital Records

(Address): Balto City Hospitals

15 Filed C. H. WILSON JONES, M. D. 19 RRH Registrar

Per 1628

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1927 to Aug 14 1927

that I last saw h[illegible] alive on Aug 14, 1927

and that death occurred, on the date stated above, at 1.20 A.m.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) L. E. Shadden M. D.

8/16 1927 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Aug 17 1927

UNIVERSITY OF MARYLAND

Outpatient Records

Per Dr. C. Randall

Check of certificates. Cause of death in plain language very important. See instructions on back of

Spec.–7-17-26—A Co.—200 Bks.

W 3349
W 24818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 49 E 24818

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roger Brook Hopkins

(a) RESIDENCE NO. Woodbrook-Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Josephine M. M. Hopkins

6 DATE OF BIRTH (month, day, and year) Feb-2-1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	60	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oil Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 645

(c) Name of employer

9 BIRTHPLACE (city or town) Md –
(State or country)

PARENTS

10 NAME OF FATHER Gerard H Hopkins

11 BIRTHPLACE OF FATHER (City or town) Md –
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz. Giles

13 BIRTHPLACE OF MOTHER (city or town) Va –
(State or country) Virginia

14 Informant Records –
(Address) ~~JOHNS HOPKINS HOSPITAL~~

15 Filed , 19 – HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1927, to Aug 16, 1927, that I last saw h~~im~~ alive on Aug 16, 1927, and that death occurred, on the date stated above, at 10.50 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Duration)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. 7 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 8-5-27

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr Alyea, M. D.

Aug 16 1927 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Friends Cemetery	Aug 18 1927
20 UNDERTAKER	ADDRESS
Wm J Jenkins Sons Co	Eutaw & Lanvale

OF DEATH in plain English. Do not use abbreviations or technical terms. Be very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 24819

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24819

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No.) Fayette & Calhoun ST. 16-68 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs - Frederick E. Heyler -

(a) RESIDENCE NO. 2818 W. Lafayette Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F. Heyler

6 DATE OF BIRTH (month, day, and year): Jan 26, 1862

7 AGE — Years: 65. Months: 6 Days: 28 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Roder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany -

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany -

14 Informant: Bertha Pohlmeyer - (Address) 2818 W. Lafayette (Mrs. Heyler)

15 Filed: Aug 20, 1927, 19.. Registrar: [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 17 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 11, 19 27, to Aug. 17, 19 27,

that I last saw he alive on Aug. 11, 19 27,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cholecystitis - operation done - cholecystotomy

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis - senile degeneration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes. Date of Aug 7, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible], M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Aug 20 1927

20 UNDERTAKER — ADDRESS

TION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Blks.

E 24820

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24820

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No.) 760 E. Fort · 24-33 St. ~~24~~ Ward

2-FULL NAME Charles Ferdinand (WADE)

(a) RESIDENCE NO. 760 E Fort St. 74 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Lamar

6 DATE OF BIRTH (month, day, and year): — — 1879

7 AGE: Years 48 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): Pulp

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Frank Wade

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Susan Miller

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Emma Lamar

(Address): 760 E Fort Ave

17 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 15 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Duration (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

Duration (duration) ..... yrs. ..... mos. ..... ds.

Signed Aug 17 19 27 (Coroner) ..... M. D.

Address 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

Date of Burial: 8/19 19 27

20 UNDERTAKER: H. F. Lahey & Sons

ADDRESS: 318 Light

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Dr Talbott
1325 Mt. North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24821

CERTIFICATE OF DEATH.

113 E 24821

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1572 Richland ST. 13-54 WARD)

2-FULL NAME Agnes Pauline Mendler

(a) RESIDENCE NO. 1572 Richland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Paul Mendler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Agnes M. Jugleng

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Agnes Mendler
(Address) 1572 Richland

15 Filed ....., 19 RPK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 1927, to Aug 16, 1927, that I last saw her alive on Aug 16, 1927 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchus pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) an Illeo Colitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed): J Edw Talbott, M. D.

Aug 17, 1927 (Address) 1355 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Aug 18 1927

20 UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

FROM EVERY imperfect

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24822

CERTIFICATE OF DEATH.

129 E 24822

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Wyoth ST. 21-22 WARD)

2-FULL NAME Eugene L. Shilow

(a) RESIDENCE NO. 621 Wyoth ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 27, 1914

7 AGE Years: 12 Months: 7 Days: 20 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wilmer Shilow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Carrie May Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Wilmer Shilow 621 Wyoth St.

15 Filed AUG 18 1927 19 R129K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1927, to Aug 17, 1927.

That I last saw h[illegible] alive on Aug 16, 1927.

and that death occurred, on the date stated above, at 6[illegible]05 A. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency & decompensation C.P.C. lungs & liver. Chr. nephritis & edema Generalized anasarca.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema & acute dilatation of heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. data

(Signed) Lewis Ehlenger M. D.

, 19 (Address) 3045 Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: London Park — DATE OF BURIAL: Aug 19 1927

20 UNDERTAKER: W. H. Cook — ADDRESS: 320 E Hoffman

TION IS VERY important. See instructions on back

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24823

CERTIFICATE OF DEATH.

17 E 24823

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) University of Md. Hospital St. (Ward)

2-FULL NAME Harry D. Ensor.

(a) RESIDENCE NO. 716 N. Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE Lydia Ryan Ensor

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Fire Ins.

(b) General nature of Industry, business, or establishment in which employed (or employer) Collector

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) " "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) " "

14 Informant Mrs. Martin

(Address) 617 N. Fayette.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Gunshot Wd. Left Wrist

(duration) ..... mos. 6hrs

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... mos. 1 hr

(Signed) J. C. Yates, M. D.

(Coroner)

Aug 17/27 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Aug 18 1927

20 UNDERTAKER Margaret L. Flynn ADDRESS 1422 Light

AUG 19 1927 H. LAMSON JONES M. D.

Registrar

Use typewriter. See instructions on back of certificate. Very important.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24824

CERTIFICATE OF DEATH.

E 24824

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Lexington Bldg St., 16-22 Ward)

2-FULL NAME Kate Marshall

(a) RESIDENCE NO. 1610 W. Lafayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND'S (or) WIFE'S Joseph Marshall.

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
Daughter	Stated	about		
	60 - She thought.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER T. Hawkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Bertha Russell

(Address) 1610 W. Lafayette St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH. (month, day, and year) Aug 15-27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv Dis. Heart

Mit Rem

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) .....yrs. .....mos. .....ds.

(Signed) H. Riley Smith M. D.

(Coroner)

Aug 17, 19 27 (Address) 1058 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem Date of Burial Aug 18 19 27

20 UNDERTAKER C. Hampton Jones M. ADDRESS 1058 Eutaw St

Aug 16 1927

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24825

CERTIFICATE OF DEATH.

74-001

E 24825

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 217 W. Hamburg St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Davis

(a) RESIDENCE NO. 217 W. Hamburg St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Cold

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Davis

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 45 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Chesapeake Steamship Co

9 BIRTHPLACE (city or town):

(State or country): NC

PARENTS

10 NAME OF FATHER: Reddick Davis

11 BIRTHPLACE OF FATHER (city or town):

(State or country): NC

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): NC

14 Informant: Rosa Davis

(Address): 217 W. Hamburg St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17 - 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Inquiry thereon and from the evidence obtained [illegible] Inquest Inquiry Verdict [illegible] and that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) At once yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed Thos. B. Horton M. D.

(Coroner)

17-A (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. *See reverse side for additional space.

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harduod Md. Date of Burial 8/18 19 27

20 UNDERTAKER: R L Pairan ADDRESS 216 S Hanover

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24826

CERTIFICATE OF DEATH.

E 24826

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 130 S Penna. Av St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Coleman

(a) RESIDENCE NO. 130 S Penna Av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced, (write the word)

Single about married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard Coleman

6 DATE OF BIRTH (month, day, and year) About 1907

7 AGE Years 25 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Leonard Coleman

(Address) 130 S. Penna Av

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

45 min

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ac. Bronchitis about 5 mos

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Pearson M. D.

(Coroner)

Aug. 19 27 (Address) 57 E Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown, Md. Date of Burial Aug 18-1927

20 UNDERTAKER Lemmert Eaton ADDRESS 716 Penn

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24827

CERTIFICATE OF DEATH.

31

E 24827

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 824 Pierce St. 18-16 (ST., WARD)

2-FULL NAME Nattie Harris

(a) RESIDENCE NO. 824 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Harris

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Household Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Ben Mackins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dorchester Co

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: John Harris

(Address): 824 Pierce

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/16 1927

17

I HEREBY CERTIFY, That I attended deceased from July 1st, 1927, to Aug 18, 1927,

that I last saw h[illegible] alive on Aug 17, 1927,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pthisis Florida

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary): Cardiac Insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Martha Goldman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 18 1927
20 UNDERTAKER: Daniel Easton	ADDRESS 916 Pa a.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24828

REGISTERED NO. 91-902 E 24828

1-PLACE OF DEATH

City of BALTIMORE: (No. 1029 Somerset St., 10th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dominick Hoblitz

(a) RESIDENCE NO. 1029 Somerset St. 10 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hoblitz

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE about — Years: 83 — Months: — — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER M. Hoblitz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant Mrs Emma Hoblitz

(Address) 1029 Somerset St

15 Filed ..... 19 ..... Registrar

J. C. HAMPSON JONES, M. D.

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 17 1927 to Aug 18 1927 that I last saw h— alive on Aug 17th 1927 and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebro Hemorrhage

Coma Lasted 2 hours

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Hampson Jones, M. D.

Aug 18. 1927 (Address) 1504 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Aug. 20 1927

20 UNDERTAKER: Henry Hoen's Son — ADDRESS: 1301 E. Eager St

Be sure to answer all questions in full. Use ink or typewriter. Do not abbreviate. Be very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24829

CERTIFICATE OF DEATH

90 E 24829

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 200 N. First St. Brooklyn Ward) 26-15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Schultz

(a) RESIDENCE NO. 200 N. First St. Brooklyn Ward

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 15 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emil P. Schultz

6 DATE OF BIRTH (month, day, and year): Feb. 1, 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	68	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER: John Born

11 BIRTHPLACE OF FATHER (City or town): (State or country) Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Germany

14 Informant: Mr. Emil P. Schultz

(Address) 200 N. First St. Brooklyn

15 Filed ..., 19... Registrar

AUG 16 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Aug 16, 1927, that I last saw her alive on Aug 16, 1927, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Valvular Heart disease

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. F. Hochheimer, M. D.

8/17, 1927 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Aug 19 1927

20 UNDERTAKER: John F Denny ADDRESS 715 Light St

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24830

CERTIFICATE OF DEATH

89 E 24830

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3803 Tait. St., 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Fisher.

(a) RESIDENCE NO. 3803 Tait. St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Kunigunda Fisher

6 DATE OF BIRTH (month, day, and year): Mch 21st 1861

7 AGE: Years 66 Months 4 Days 25 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Caspar Fisher.

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Adam Philipp Fisher

(Address) 3821 Foster Ave.

15 Filed AUG 18 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 16th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1926, to Aug 16, 1927, that I last saw him alive on Aug 16, 1927, and that death occurred, on the date stated above, at 11 49 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) 806 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery Date of Burial: Aug 1927

20 UNDERTAKER: Lilly & Gilles ADDRESS 403 S. Wolfe St

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47

REGISTERED NO. E 24831

1-PLACE OF DEATH

City of BALTIMORE: (No. 9 E. Hamilton Ave St., 27-47 Ward)

2-FULL NAME Mary Elizabeth Wilson

(a) RESIDENCE NO. 9 E. Hamilton Ave St. 27 Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John R. Wilson

6 DATE OF BIRTH (month, day, and year): June 25th 1877

7 AGE — Years: 50 Months: 1 Days: 20 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Alexander Miener

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Margaret Kratz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto.

14 Informant: John R. Wilson

(Address): 9 E. Hamilton ave.

15 Filed , 19 Registrar

By R.M.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 15th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to August 15, 1927, that I last saw h[illegible] alive on August 15, 1927, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) yrs. mos 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Blume, M. D.

(Address) 1734 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Park Wood Cemetery — Date of Burial: Aug 18th 1927

20 UNDERTAKER: Luby & Zeller — ADDRESS: 1630 Aliceanna St

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Relative of Brunhart

E 24832 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

129 E 24832

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 Fairview Ave St. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena N. Gerhart

(a) RESIDENCE NO. 605 Fairview Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas

6 DATE OF BIRTH (month, day, and year) Dec. 25-[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Henry Halfpad

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Cath Kemm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Kemm

14 Informant Mrs Chas Gerhart (Address) 605 Fairview Ave

15 Filed [illegible] 19 [illegible] By R H K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 16 1927

17

I HEREBY CERTIFY, That I attended deceased from August 15, 1927, to August 16 1927, that I last saw h[illegible] alive on August 15, 1927 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows: Coronary

Thrombosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos L. Valentine M. D.

(Address) 14 So Broadway

August 18 19 27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mathews Cem.

DATE OF BURIAL 8 1927

20 UNDERTAKER Wm Cook

ADDRESS [illegible]

Spec.–7-17-26–A Co.—200 Bks.

E 24833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 49 ✓ E 24833

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hosp.

City of BALTIMORE: (No. Calvert & 33rd St. 12-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elaine Dowling

(a) RESIDENCE NO. Kuper W. Va. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 5 1924

7 AGE — Years: 2 Months: 10 Days: 12 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Kuper W. Va

(State or country)

PARENTS

10 NAME OF FATHER Wallace Dowling

11 BIRTHPLACE OF FATHER (City or town) Grafton W. Va

(State or country)

12 MAIDEN NAME OF MOTHER Hazel Fillen

13 BIRTHPLACE OF MOTHER (city or town) Moorefield W. Va

(State or country)

14 Informant Mother

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17 1927 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 19 27, to Aug. 17, 19 27.

that I last saw her alive on Aug 17, 19 27.

and that death occurred, on the date stated above, at 7:45 P.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor (Right frontal lobe.)

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Convulsions Seizures

(duration) 2 yrs. 1 mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Wallace K. Swartwelder M. D.

19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Keyser W. Va. Date of Burial: Aug 18 19 27

20 UNDERTAKER: H. C. Cook ADDRESS 300 E. North Ave

Check of certificates. See instructions on back of this page. Items very important.

C. HARRISON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 24834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24834

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 Dolphin ST., 17-24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Jackson

(a) RESIDENCE NO. 721 Dolphin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgiana Jackson

6 DATE OF BIRTH (month, day, and year) [illegible] 6

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Montreal Canada
(State or country)

PARENTS

10 NAME OF FATHER Chas Jackson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Montreal Canada

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Montreal Canada

14 Informant Georgiana Jackson
(Address) 721 Dolphin St.

15 Filed , 19 Per C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 19

17

I HEREBY CERTIFY, That I attended deceased from Aug 14, 1927, to Aug 17, 1927, that I last saw him alive on Aug 16, 1927, and that death occurred, on the date stated above, at 3-10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical ex. symptoms

(Signed) Wm A Evans, M. D.

, 19 (Address) 1200 Penn Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

TION is very important. See instructions on back

Spec.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24835

CERTIFICATE OF DEATH.

31 ✓

E 24835

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 6-10 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yetta Greenberg

2100 Bath St

(a) RESIDENCE NO. Bath & Chester St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ___ mos. ___ ds. How long in U. S., if at foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	~~Divorced~~

5a If married, widowed or divorced HUSBAND of (or) WIFE of Sol Greenberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) ?

(State or country) Austria

10 NAME OF FATHER Mendal adler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Shone —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Hospital Record

(Address)

15 Filed_____, 19____ R.M.L. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18/1927. 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1927, to Aug 18, 1927, that I last saw her alive on Aug 18, 1927, and that death occurred, on the date stated above, at 3.35 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

?

(duration) ? yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? X-Ray - Sputum Examination

(Signed) John Aaron Austin, M. D.

8/19, (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial Hebrew Herren Ruh 8/18 19 27

20 UNDERTAKER ADDRESS Jack Levin 1419 E Balto St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24836 E 24836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2412 E. Hoffman St. 8-16 WARD)

2-FULL NAME Richard J. Concannon Jr.

(a) RESIDENCE NO. 2412 E. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 30, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Richard J. Concannon

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Tiernan

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mr. R. Concannon
(Address) 2412 E. Hoffman St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1927, to Aug 17, 1927, that I last saw h[illegible] alive on Aug 16, 1927, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Pertussis Measles and Bronchs-Pneumonia

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs

(Signed) W H Pearce, M. D.

, 19 (Address) 2105 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Aug 18 1927

20 UNDERTAKER Rida Woodfield & Grumbrecht — ADDRESS

TION IS very important

Spec.—1-10-21—M&T—1500 Bks.

E 24837 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24837

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2431 Foster Ave ST. 1st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Simmel

(a) RESIDENCE NO. 2431 Foster Ave ST. 1st WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Simmel

6 DATE OF BIRTH (month, day, and year) Jan 13 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Funeraman

(b) General nature of industry, business, or establishment in which employed (or employer) at B.E. S & R Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Elizabeth Simmel

(Address) 2431 Foster Ave

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

AUG 16 1927 RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1927, to Aug 17, 1927

that I last saw him alive on Aug 16, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency.

(duration) — yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Peter McCauley M. D.

Aug 17, 1927 (Address) 3508 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem DATE OF BURIAL Aug 17 1927

20 UNDERTAKER Peter Nicolaus ADDRESS 2923 Eastern Ave

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24838

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

120

E 24838

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., Ward)

REGISTERED NO. 5321

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Denman

(a) RESIDENCE NO. 1621 N. Vincent St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 42 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Name unknown

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: 42 Years / Months Days

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER: Abraham Strickland

11 BIRTHPLACE OF FATHER (City or town): Balt.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER: Josephine Slater

13 BIRTHPLACE OF MOTHER (City or town): Balt.

(State or country) Maryland

14 Informant: Esther Grant

(Address) 1604 N. Vincent St.

15 Filed ..., 19 ...

Registrar

Per RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1927, to Aug 15, 1927, that I last saw her alive on Aug 15, 1927, and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Yellow Atrophy of Liver.

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary): Pleurisy (chronic)

(duration) ... yrs. ... mos. 20 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Henry C. Smyth, M. D.

Aug 17, 1927 (Address) Balt. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet

Date of Burial: Aug 19 1927

20 UNDERTAKER: Jos. H. Oliver & Son

ADDRESS: 1201 N. Pine

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24839

CERTIFICATE OF DEATH.

E 24839

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Md Gen Hosp (St.) 16-18 (Ward)

2-FULL NAME David Ely

(a) RESIDENCE NO. 2811 Brighton (St.) _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 50 yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Ely

6 DATE OF BIRTH (month, day, and year) Sept. 3-1853

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	73	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B.C.+a. Ry.

9 BIRTHPLACE (city or town)

(State or country) England.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not known

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not known

14 Informant Eva. Hutchinson

(Address) 2811 Brighton St.

15 Filed _____ 19____ CHAS. N. JONES, M. D.

Per RKL Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 7 yrs. 3 mos. ___ ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) ___ yrs. ___ mos. 1 ds.

Aug 16 1927 (Signed) G. M. Gladden M. D.

(Coroner)

(Address) 1436 Kirby

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cem.	Aug 19 1927
20 UNDERTAKER	**ADDRESS**
George W. Zibler	1737 E. Eager St.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24840

CERTIFICATE OF DEATH.

E 24840

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital ST. 15 WARD)

2-FULL NAME Alice Stolsky

(a) RESIDENCE NO. 513 S. Linwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced —~~HUSBAND of~~ (or) WIFE of: Andrew Stolsky

6 DATE OF BIRTH (month, day, and year): April 23, 1895

7 AGE: Years 32 Months 3 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: George Dannenfelser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Amelia Yager

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Amelia Dannenfelser (Address) 822 S. Clinton St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1 1927 to Aug. 17 1927

that I last saw her alive on Aug. 14 1927

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis Confirmed Pregnancy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? thoracentesis Date of Aug. 14th

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry D. Kolb M. D.

Aug. 19/27 (Address) 1703 Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cemetery — DATE OF BURIAL: Aug 20 1927

20 UNDERTAKER: George W. Zinkler — ADDRESS: 1737 E. Eager St

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 E 24841

REGISTERED NO.

E 24841
1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3826 Foster ave ST. 26-37 WARD)

2-FULL NAME George R. Bomhardt

(a) RESIDENCE NO. 3826 Foster ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Bomhardt

6 DATE OF BIRTH (month, day, and year) July 27-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna R.R.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christopher Bomha

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Minnie Bomhardt
(Address) 3826 Foster ave

15 Filed AUG 18 1927 Registrar RKL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to Aug 17, 1927, that I last saw h— alive on Aug 17, 1927 and that death occurred, on the date stated above, at 3:55 a m

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis —

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Coma —

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Thos O'Bonner, M. D.

, 19 (Address) 125 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL aug 21 1927

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E Eager

Spec.-7-17-26—A Co.—200 Bks.

E 24842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 24842

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2039 E Oliver St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizebeth Mc Carty

(a) RESIDENCE NO. 2039 E Oliver St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michel Mc Carty

6 DATE OF BIRTH (month, day, and year): Dont Know 1865

7 AGE: Years 62. Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: John J. Mc Carty

(Address): 2039 E Oliver St

15 Filed ..... 19 .....

Registrar

C. HUMSON JONES, M. D.

AUG 19 1927

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/10, 1927, to 8/17, 1927, that I last saw her alive on 8-17, 1927, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Mitral Regurgitation

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) David Miller, M. D.

8/18, 1927 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Aug 20 1927

20 UNDERTAKER: Robt J Turner Sr — ADDRESS: 1313 E Baltimore

Of DEATH is prima facie evidence of the fact of death and should be filed with the Registrar of Vital Statistics, very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24843

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24843

CERTIFICATE OF DEATH

1-PLACE OF DEATH Provident Hospital 161-00

REGISTERED NO.

City of BALTIMORE: (No. 14-20 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Washington

(a) RESIDENCE NO. Provident Hospital St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8-16-27

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
				8 hours

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Taylor

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Howard Co Md.

12 MAIDEN NAME OF MOTHER Ruth C Washington

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Howard Co Md.

14 Informant

(Address)

15 Filed 1927 Per 1629

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-16-27, 19, to 8-16-27, 19,

that I last saw h— alive on 8-16-27, 19,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Prematurity — 7 months

Pul. congestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

. 19 (Address) 405 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

AUG 13 1927

Check of certificates. See instructions on back of certificates. very important.

Spec.–7-17-26—A Co.—200 Bks.

E 24844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

164 E 24844

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 829 Woodward St. 7-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christianna Schelhase

(a) RESIDENCE NO. 829 Woodward St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 6 mos. — ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Schelhase

6 DATE OF BIRTH (month, day, and year) Feb 28 1833

7 AGE: Years 92 Months 5 Days 20

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Betz

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Henry W. Schelhase 829 Woodward St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 19 27, to Aug 17, 19 27, that I last saw h[illegible] alive on Aug 17, 19 27, and that death occurred, on the date stated above, at 8 45 a. m.

The CAUSE OF DEATH* was as follows:

General debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D. Smillie M. D.

8/18, 19 27 (Address) 662 Work Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial Aug 20 1927

20 UNDERTAKER: Jos Joerdens & Son — ADDRESS 207 S. Ha

Of Death in plain [illegible] of certificates.

very important. See instructions on back

E. C. HAMILTON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24845

CERTIFICATE OF DEATH.

179 E 24845

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 S. ~~Caroline~~ Chapel St. ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Kueslein

(a) RESIDENCE NO. 233 S. ~~Caroline~~ Chapel St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): School girl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 1916

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
10	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Joseph Kueslein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Katherine Benzing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant (Address) Joseph Kueslein 233 S Chapel

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1927, to Aug 17, 1927, that I last saw h~~er~~ alive on Aug 17, 1927, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? St Louis

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? analysis

(Signed) Morgan Graham, M. D.

, 19 (Address) 1904 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem

DATE OF BURIAL: Aug 20 1927

20 UNDERTAKER: Randall Riggs & Son

ADDRESS: 378 Penn

TION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

Ward B

E 24846

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24846

CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Hogan

(a) RESIDENCE NO. 3520 Parkdale Ave. Woodbury, Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rachel Hogan

6 DATE OF BIRTH (month, day, and year): Unknown 1855

7 AGE: Years 72 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant: Hospital Records (Address)

15 Filed AUG 18 1927, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/18/27 19

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to 8/18/27, 19, that I last saw h[illegible] alive on 8/18/27, 19, and that death occurred, on the date stated above, at 7.45 pm m.

The CAUSE OF DEATH* was as follows:

Cardio-renal disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Winstead M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alla Cem. Bald A. Date of Burial: Aug 21 1927

20 UNDERTAKER: Easton Sons ADDRESS: Ellicott City

Be sure that all items are answered. Use "unknown" or "none" where necessary. Do not leave blanks. Physicians are requested to fill certificates very important. See instructions on back of certificates.

Co.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24847

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

1857

E 24847

REGISTERED NO.

City of BALTIMORE: (No. St Joseph Hosp St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie C. Hilditch

(a) RESIDENCE NO. 2510 E Mon St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7 1857

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	70	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not Known

12 MAIDEN NAME OF MOTHER Sarah Gradle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Hilditch

(Address) 2510 E. Monument St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Fall down steps.

Fracture of Skull

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) G C Steele M. D.

(Coroner)

19 (Address) 143 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem Date of Burial Aug 21 1927

20 UNDERTAKER Edward Bodenschatz ADDRESS 1543 Aisquith St

AUG 20 1927 HAMILTON JONES, M. D.

Of Deaths of persons who died in Baltimore. See instructions on back of certificate. Very important.

Spec.–7-17-26—A Co.—200 Bks.

20567

E 24848

1-PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37-081 E 24848

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Pack

(a) RESIDENCE NO. 1606 N Dallas St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1y yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17 - 1926

7 AGE Years: 11 Months: 10 Days: 29

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to Aug 17, 1927,

that I last saw h[illegible] alive on Aug 17, 1927,

and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) 0 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted at home 1606 N Dallas St.

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? X Ray

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn Cem	Aug 19 1927
20 UNDERTAKER Wm R A Elliott	ADDRESS 1727

OF DEATH in plain terms, so that it may be very important. See instructions on back of

AUG 19 1927

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24849

CERTIFICATE OF DEATH.

31 E 24849

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 Sherwood Avenue. 9-46 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Vogl

(a) RESIDENCE No. 1904 Sherwood Avenue ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Vogl

6 DATE OF BIRTH (month, day, and year): July 23? 1860

7 AGE: Years 67 | Months | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): Fred. Bauschmidt Brewery.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Vogl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Mary Vogl
(Address): 1904 Sherwood Avenue

15 Filed ..... 19 ..... Registrar

TION is very important See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17 1927

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1927, to Aug 16, 1927.

that I last saw h[illegible] alive on Aug 16, 1927

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart; Myocarditis;

(duration) X yrs. X mos 7 ds.

CONTRIBUTORY (Secondary): Pulmonary Tuberculosis

(duration) X yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Analysis

(Signed) J. H. Burke, M. D.

(Address) 928 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 8 | 20 1927

20 UNDERTAKER: George J Ruth

ADDRESS: 1735 Harford Avenue

AUG 1927

Spec.—7-17-26—A Co.—200 Bks.

E 24850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

REGISTERED NO. E 24850

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 9-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Shade

(a) RESIDENCE NO. 1611 Lamont ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Shade

6 DATE OF BIRTH (month, day and year) May 12 1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.,
	48	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) B & O.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt. Co

PARENTS

10 NAME OF FATHER William Shade

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balt. Co.

12 MAIDEN NAME OF MOTHER Ann. Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Margaret Shade (Address) 1611 Lamont Av

15 Filed . . . . . 19 . . . . . Registrar

RLK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-17-'27

17 I HEREBY CERTIFY, That I attended deceased from 8-10-'27, 19 , to 8-17-27, 19 , that I last saw h alive on 8-7-'27, 19 , and that death occurred, on the date stated above, at 7 05 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio Vascular disease & auricular fibrillation

(duration) 4-5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Embolism

3 minutes (duration) duration mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Coroner

Mount Moriah Cemetery · Aug 20, 1927

20 UNDERTAKER ADDRESS

Geo. F. Ruth 1730 Harford ave

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 24851

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Senge

(a) RESIDENCE NO. 812 N. Calhum St. Ward city
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 188

7 AGE: Years 46 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Genge Savage

11 BIRTHPLACE OF FATHER (City or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Kelly

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Records –
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

OF DEATH in plain terms, so that a ... may be very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927, to Aug 17, 1927, that I last saw her alive on Aug 17, 1927, and that death occurred, on the date stated above, at 7:55 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Pancreas with pulmonary
General Tuberculosis Intestinal stasis
hepatic and peritoneal metastases
(duration) yrs. 7 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy

(Signed) Robt. L. Faithfner, M. D.
, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nassawadox Station — Date of Burial: Aug 19 1927

20 UNDERTAKER [illegible] John H. Trodin — ADDRESS 1027 Lanvale

AUG 1927

Cor.—12-9-25—A Co.—200 Bks.

E 24852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 24852

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1321 W. Mosher St. 16-23 Ward)

2-FULL NAME Wm. H. Johnson

(a) RESIDENCE NO. 1321 W. Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	Color	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Johnson

6 DATE OF BIRTH (month, day, and year) about 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs. Mattie Johnson

(Address) 1321 W. Mosher St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Old history

(duration) yrs. mos. ds.

(Signed) J. C. Thomas, M. D.

(Coroner)

Aug 16, 1927 (Address) 702 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial Aug 19 1927

20 UNDERTAKER John H. Trader ADDRESS 1027 Lombard

Cut on this line

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24853

CERTIFICATE OF DEATH.

139 E 24853

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 116 Perry St 22-30 Ward)

2-FULL NAME Addie Johnson

(a) RESIDENCE NO. 116 Perry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Wm. Johnson
(Address) 116 Perry

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to my death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fibroid tumor uterus

Cardiac dilatation (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Riley M. D.
(Coroner)

, 19 (Address) 1619 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial 1927

20 UNDERTAKER C. A. Braun & Son ADDRESS 108 W. Monument St

Cor. of Death is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 24854
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen Hosp St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Caroline Cather

(a) RESIDENCE NO. 38 N Biddle St. Ward Port Deposit Md.

(Usual place of abode) about

Length of residence in city or town where death occurred / yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 20 1850

7 AGE: Years 76 Months 11 Days 29

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Philadelphia

(State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: John Lamb

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER: Caroline Weaver

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Hospital Record

(Address)

15 Filed ..... 19 ..... C. H. ..... Registrar

Per RLC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1927, to August 19, 1927, that I last saw h.. alive on August 18, 1927, and that death occurred, on the date stated above, at 2.55 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Acute dilatation

Cardiac (duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Compston M. D.

, 19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Nottingham Cem Port Deposit Md Date of Burial Aug 22 27

20 UNDERTAKER: Lee A. Patterson ADDRESS Perryville Md.

AUG 19 1927

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24855

CERTIFICATE OF DEATH

16-007

E 24855

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1605 N Franklin St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mack Wilson Generette

(a) RESIDENCE NO. 1605 N Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 18-87

7 AGE: Years 4 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md

PARENTS

10 NAME OF FATHER Norman Generette

11 BIRTHPLACE OF FATHER (City or town) S. C.

(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Ward

13 BIRTHPLACE OF MOTHER (city or town) S. C.

(State or country)

14 Informant Norman Generette

(Address) 1605 N Franklin St

15 Filed , 19 Registrar

AUG 3 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1927, to Aug 18, 1927, that I last saw him alive on Aug 17, 1927, and that death occurred, on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows:

Enteric Colitis and Pyorrhoea Alveolaris

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pyorrhoea Alveolaris (durotion) yrs. ? mos. ? ds.

18 Where was disease contracted

If not at place of death? not known

Did an operation precede death? no Date of no

Was there an autopsy? yes

What test confirmed diagnosis? Physical Exam

(Signed) G. L. Blake, M. D.

, 19 (Address) 4266 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem Date of Burial: Aug 1927

20 UNDERTAKER: Samuel H. Hensley ADDRESS: Balto

OF DEATH in plain terms, and answer every question. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Blks.

Turell.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

~~4544~~ E 24856 — 44 E 24856

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 2-19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wales Randolph Turell

(a) RESIDENCE NO. 201 - 201½ St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Tyrell

6 DATE OF BIRTH (month, day, and year) June 11 - 1882

7 AGE	Years	Months	Days
	45	2	5

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Charles Turnell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Celia Burrows

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug - 17 - 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927, to Aug 17, 1927, that I last saw him alive on Aug 17, 1927, and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. 22 mos. 3 da.

CONTRIBUTORY (Secondary) Carcinoma of Oesophagus

(duration) yrs. 9 mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Necy

(Signed) Lyman Wells M. D.

Aug 17, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial 8/19/27

20 UNDERTAKER Samuel H. Linsley ADDRESS 538 N. Eutaw

AUG 19 1927 (illegible)

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24857

CERTIFICATE OF DEATH.

17 E 24857

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 605 Gravtly St., 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur N Hetrick

(a) RESIDENCE NO. 605 Gravtly St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ira & Hetrick

6 DATE OF BIRTH (month, day, and year) Nov 2 - 1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Route Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

(c) Name of employer Diehl "

9 BIRTHPLACE (city or town)_____

(State or country) Penna

PARENTS

10 NAME OF FATHER Samuel Hetrick

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) ~~Penna~~ South Penna

12 MAIDEN NAME OF MOTHER Lucy Smith

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Penna

14 Informant Mrs Ira E Hetrick

(Address) 605 Gravtly St

15 Filed_____ 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - Razor Cut of Throat

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) Wm G Yates M. D.

(Coroner)

18 (Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Freedom, Pa — Date of Burial Aug 20 1927

20 UNDERTAKER Wm J Gardner Sons — ADDRESS Hyde

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24858

CERTIFICATE OF DEATH.

E 24858

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2320 Guilford Ave ST. 17-50 WARD)

2-FULL NAME Louis Snowden

(a) RESIDENCE NO. 2320 Guilford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Snowden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Bray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Bookes (Address) 2320 Guilford Ave

15 Filed 19 Per Registrar

C. H. JONES, M. D.

AUG 19 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927 to Aug 16, 1927.

that I last saw h alive on Aug 16, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry H Weinberger M. D.

8/11, 1927 (Address) 720 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Aug 19, 1927

20 UNDERTAKER: Mrs. P. C. Elliott — ADDRESS: 1725 Ashland Ave.

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

24859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Dept of H 24859

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2511 W. North Ave. St., 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Bruner Heckman

(a) RESIDENCE NO. 2511 W. North Ave St. Ward Resident

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. ? mos. ? ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 70 yrs. 1 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June - 20 - 1857

7 AGE — Years: 70 Months: 1 Days: 28 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General natore of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) Easton

(State or country) Penna

PARENTS

10 NAME OF FATHER John H. Heckman

11 BIRTHPLACE OF FATHER (City or town) Easton

(State or country) Penna

12 MAIDEN NAME OF MOTHER Esther Johnston

13 BIRTHPLACE OF MOTHER (city or town) Bristol

(State or country) Penna

14 Informant: Mrs Anna E Bowie (sister)

(Address) Normandy Apts.

15 Filed ..... 19 ..... CHAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1920 to Aug 16, 1927, that I last saw her alive on Aug 16, 1927, and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis · Hypertension

(duration) 15 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Examination

(Signed) H A Dorsey, M. D.

Aug 19 1927 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — Date of Burial: Aug 19 1927

20 UNDERTAKER: Stewart & Co. — ADDRESS: Balto.

DEATH to be filed with the Registrar of the district in which death occurred within 24 hours. Use typewriter or pen and ink. Every question must be answered, or the reason for omission stated. Information must be given by person best informed. Physician must fill out and sign medical certificate. Undertaker must fill out and sign burial certificate. Please read carefully the instructions on back of certificates. very important. See instructions on back

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24860

E 24860

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Smith Ave - Dorchester (STREET) (WARD) Lakeland 2-73

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Stanley Griffith

(a) RESIDENCE NO. Smith Ave - Dorchester ~~Hgts~~ STREET WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine B Carman

6 DATE OF BIRTH (month, day, and year): Nov. 15, 1862

7 AGE — Years: 64 Months: 9 Days: 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Ry Office

(c) Name of employer: (Retired) So Ry Co Richmond Va

9 BIRTHPLACE (city or town) (State or country): Chislehurst Kent - England

PARENTS

10 NAME OF FATHER: Edward Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country): England -

12 MAIDEN NAME OF MOTHER: Charlotte Cobb -

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Eliz. A. Praylehurst

(Address): Smith Ave Dorchester

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from 4 May, 1927, to 17 Aug, 1927, that I last saw h~~im~~ alive on 17 Aug, 1927, and that death occurred, on the date stated above, at 10:20 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arsinoma Lungs -

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Caldwell Woodruff, M. D.

(Address) Linthicum Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: Aug. 20 1927

20 UNDERTAKER: Nelson E. Stiles

ADDRESS: 231 Md. Ave Westport

TION is very important - See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24861 E 24861

CERTIFICATE OF DEATH.

Norwood Heights 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Hazlett ST. 28-71 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick F. Lindauer

(a) RESIDENCE NO. 402 Hazlett ST. Norwood Heights WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie C. Lindauer

6 DATE OF BIRTH (month, day, and year) April 9, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood-carver 0[14]

(b) General nature of industry, business, or establishment in which employed (or employer) retired about

(c) Name of employer 1 year.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Christian Lindauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rosina Gesswein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Carrie Lindauer (wife)

(Address) 402 Hazlett Ave

15 Filed ... , 19 ... Registrar

For Ruf

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to Aug 18, 1927.

that I last saw him alive on Aug 17, 1927

and that death occurred, on the date stated above, at 1230 A m.

The CAUSE OF DEATH* was as follows:

Asthma

Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clin. Exam

(Signed) Frank E. Magner M. D.

8/19, 1927 (Address) 1076 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 20 1927
20 UNDERTAKER	ADDRESS
Nelson E. Stiles	231 Md. Ave Westport

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24862

CERTIFICATE OF DEATH.

31 E 24862

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 N Collington ST.: 8-16 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest F. Schroeder

(Residence in Baltimore: No. 1509 N Collington St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, May (Month) 4 (Day), 1863 (Year)

7-AGE, 64 yrs. 3 mos. 13 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Collector
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, Fredk W. Schroeder

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Marie E Lumpe

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fredk W. Schroeder.

(Address) 1509 N. Collington Ave

15-

Filed ....., 191.....

AUG 19 1927 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 17 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 16 1927, to Aug 17 1927, that I saw h alive on Aug 17 1927, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. E. Kerner M. D.

Aug 18, 1927 (Address) 130 N Paca St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Aug. 20 1927

20-UNDERTAKER John Ullrich

ADDRESS 2108 Arlington Ave

Important: Use Indelible Pencil.

Spec.—8-24-14—M. & T.—2000 Bks.

E 24863

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24863

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 N. Washington ST. 16-9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Gold

(Residence in Baltimore: No. 16 N. Washington St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Unknown, 1 .....
(Month) (Day) (Year)

7-AGE, 56 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Isaac E. Gold

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Max Gold .....

(Address)..... 1722 N. Payson St.

15-

Filed ....., 191.....

C. HAMPSON JONES, M. D.
AUG 19 1927
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August (Month) 19 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1 1917, to Aug. 19 1917, that I saw him alive on Aug. 15 1917, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

..... Carcinoma of Larynx .....

.....

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral embolus

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) ..... B. Kaden M. D.

Aug. 19, 1917 (Address) 2306 E. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship

DATE OF BURIAL, 8/19 1917

20-UNDERTAKER Jack Levin

ADDRESS 1439 Eutaw

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24864

CERTIFICATE OF DEATH.

49 E 24864

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2072 Linden ave ST., 14-20 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frieda Belor

(a) RESIDENCE No. 2072 Linden ave ST., ... WARD ..... Baltimore, Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 31 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	16	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md

PARENTS

10 NAME OF FATHER Sam Belor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Gardinsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sam Belor
(Address) 2072 Linden ave

15 Filed ....., 19.... Registrar

AUG 19 1927 C. HAMPTON JONES M.D. CHK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1925, to Aug-19, 1927, that I last saw h alive on July 28, 1927, and that death occurred, on the date stated above, at 6-30 4 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of glands of neck.

(duration) 2 yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination, X-ray, etc

(Signed) Robert E. Fricke, M. D.

, 19 (Address) 1418 Eutaw Place City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	8/19/27 19
20 UNDERTAKER	ADDRESS
Jacob Lewis	1439 Eutaw

TION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24865

CERTIFICATE OF DEATH.

113 E 24865

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2234 Stanley St. 6-10 Ward)

2-FULL NAME Beulah E. Elliott

(a) RESIDENCE NO. 2234 Stanley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4th 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		3	8 9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) City

PARENTS

10 NAME OF FATHER Jesse E. Elliott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Shorter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Jesse E. Elliott

(Address) 2234 Stanley St.

15 Filed ..... 19 ..... Registrar

G 13 1927 Per C. HAMPTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

Aug 9 1927 (Signed) G C Hades M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Olivet Cemetery	8/12 1927

20 UNDERTAKER	ADDRESS
E. J. Fanning & Son	1460 Battery ave.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 24866

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24866

CERTIFICATE OF DEATH.

10-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 19-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Frank Reed Jr.

(a) RESIDENCE NO. 1524 McHenry St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 16-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	6	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Louis Frank Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co. Md

12 MAIDEN NAME OF MOTHER Christine Ruhlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Louis Frank Reed

(Address) none

15 Filed 19

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-19-27 19

17

I HEREBY CERTIFY, That I attended deceased from 8-14-27, 19 , to 8-19-27, 19 ,

that I last saw him alive on 8-19-27, 19

and that death occurred, on the date stated above, at 6. A. m.

The CAUSE OF DEATH* was as follows:

Tonsilar Diphtheria

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL Aug 20th 1927

20 UNDERTAKER A. Jones ADDRESS 111 S. Gilmor St

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Marek

205-614

E 24867

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24867

CERTIFICATE OF DEATH

× 24

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Constance Marek

(a) RESIDENCE NO. 119 York St - Hanover Ward Pa

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) December

7 AGE: Years — Months 2 — Days — IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ohd

(c) Name of employer

9 BIRTHPLACE (city or town) Pa —

(State or country)

PARENTS

10 NAME OF FATHER Ralph

11 BIRTHPLACE OF FATHER (City or town) N. Y. —

(State or country)

12 MAIDEN NAME OF MOTHER Katherine Heman

13 BIRTHPLACE OF MOTHER (city or town) Pa —

(State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... JOHNS HOPKINS H. D. Registrar

AUG 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to Aug 18, 1927, that I last saw her alive on Aug 18, 1927, and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

Meningococcus Meningitis

(duration) ....yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? Hanover Pa

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) D. R. Thayer, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's McSherrystown Pa — Date of Burial: Aug 20 1927

20 UNDERTAKER: W. J. Ferner — ADDRESS Hanover

OF DEATH in plain terms, ... certificates. very important. See instructions on back of cer...

Spec. 7-17-26—A Co.—200 Bks.

E 24868

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24868

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Nancy Harriet St. 1355 Ward 11)

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. L. Weis

(a) RESIDENCE NO. 3526 Hickory Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 28 1918

7 AGE: Years 8 Months 7 Days 20

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Scholar

(b) General nature of industry, business, or establishment in which employed (or employer): City College

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Wm. L. Weis

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Ellen R. Corwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Wm. L. Weis

(Address): 3526 Hickory Ave

15 Filed 1927 19

C. HAMPSON JONES, M. D.

Per

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-18-27 19

17

I HEREBY CERTIFY, That I attended deceased from 8-15-27 to 8-18-27 19

that I last saw h[illegible] alive on 8-18-27 19

and that death occurred, on the date stated above, at 12 34 m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

Operation Appendicitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

Appendicitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted at home

if not at place of death?

Did an operation precede death? Yes Date of 8-15-27

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Aug 30 1927

20 UNDERTAKER: A S Marshall — ADDRESS: 353 Park Ave

OF DEATH in plain terms, so that it may be properly classified, certificates, very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24869

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24869

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2742 Huntingdon Ave (St.) 12-51 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Kennedy

(a) RESIDENCE No. 2742 Huntingdon Ave (St.) ... WARD ...
(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk. 009

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery Store

(c) Name of employer: John T. Conway

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Martin Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ella Rafferty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: John T Conway
(Address): 2742 Huntingdon Ave

15 Filed ... , 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 18 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1923 to Aug 18 1927, that I last saw him alive on Aug 17 1927, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): Intestinal Affection

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs and examination of urine

(Signed) R R Norment, M. D.

8,18, 1927 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral — DATE OF BURIAL: Aug 20 1927

20 UNDERTAKER: A S Marshall — ADDRESS: 2539 Eutaw St.

TION is very important. See instructions on back of certificates.

9 1927 C. HAMPSON JONES, M. D.

Spec. -7-17-26—A Co.—200 Bks.

E 24870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 24870

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Percy Wyeth Willis

(a) RESIDENCE NO. 35-7 W Preston St. Ward Calv-

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER Harry Wyeth Willis

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Addie Lee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Parents

(Address) ~~JOHNS HOPKINS HOSPITAL~~

15 Filed ..... 19.... C. HAMPSON JONES, M. D. Registrar

Per RKW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to Aug 18, 1927, that I last saw him alive on Aug 18, 1927, and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Brain tumor, pituitary

non malignant

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of Aug 17, 1927

Was there an autopsy? yes

What test confirmed diagnosis? Operation autopsy.

(Signed) W. D. Stout M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Portsmouth Va	Aug 19 1927
20 UNDERTAKER Lund Eaton	ADDRESS Balto

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificates.

AUG 19 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24871

CERTIFICATE OF DEATH

1-001

E 24871

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry White

(a) RESIDENCE NO. 1721 W Franklin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 44 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Annie White

(Address) 1721 Franklin St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 11, 1927, to Aug 19, 1927, that I last saw h[illegible] alive on Aug. 18, 1927, and that death occurred, on the date stated above, at 5:00 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? N. Jersey

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Widal

(Signed) John W. Gaines, M. D.

, 19 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn Cem	Aug 19 1927

20 UNDERTAKER Daniel Carter & Co ADDRESS 916 Pa ave.

Check of certificates. See instructions on back of certificates. very important.

AUG 19 1927 C. LINCOLN JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 24872

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24872

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2227 Washington Blvd ST. 2572 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Mary Happel

(a) RESIDENCE NO. 2227 Washington Blvd ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 16-1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	W	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Herman Happel.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Ida Happel. Aug 19, 1927 (Address)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Herman Happel 2227 Washington Blvd

15 Filed ... 19... Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1927, to Aug 19, 1927, that I last saw her alive on Aug 18, 1927, and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia and Enteritis

(duration) no yrs. no mos 7 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Bloody Feces.

(Signed) Raymond D Adams, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: Aug 22 1927

20 UNDERTAKER: John J Reilly — ADDRESS: 1200 W Lexington

TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

E 24873

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24873

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Parkin ST. 18-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Hancke

(a) RESIDENCE NO. 108 Parkin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 7th 1875

7 AGE: Years 52. Months 3 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Adolph Hancke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Johanna Uttke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Mr. Adolph Hancke 108 Parkin St.

15 Filed 17 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1. 1927. to Aug 17th 1927. that I last saw h e alive on Aug 17th 1927, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Thos. [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem DATE OF BURIAL: Aug 20th 1927

20 UNDERTAKER: John F Cowan & Son ADDRESS: 901 Hollins

C. HAMPSON JONES, M. D.

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 24874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 57 ✓E 24874

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3532 E. Fairmount ave. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daily Moultrie Jackson.

(a) RESIDENCE NO. 3532 E. Fairmount ave. 26 Ward Monks Corner S. C.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lola Muldrew Jackson

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) S. Carolina
(State or country)

PARENTS

10 NAME OF FATHER Pringle Jackson

11 BIRTHPLACE OF FATHER (City or town)
(State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. Carolina

14 Informant Walter E. Palmer
(Address) 3532 E. Fairmount ave.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1927, to Aug. 18, 1927, that I last saw him alive on Aug. 18, 1927, and that death occurred, on the date stated above, at 1045 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus, followed by diabetic gangrene of the right foot.

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas M. D.

8-19 1927 (Address) 3037 E Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Family Plot in South Carolina — Date of Burial Aug 21 1927

20 UNDERTAKER Monks Corner Kelly & Zuber — ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that very important. See instructions on back of certificates.

AUG 19 1927 C. HAMPSON JONES, M. D. Registrar

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24875

CERTIFICATE OF DEATH

129 E 24875

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 100 S. Schroeder St. 16-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kroeger

(a) RESIDENCE NO. 100 S. Schroeder St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 13, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	64	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Kroeger

11 BIRTHPLACE OF FATHER (City or town) Lubbecke

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Marquerding

13 BIRTHPLACE OF MOTHER (city or town) Hanover

(State or country) Germany

14 Informant Kate C. Kroeger

(Address) 100 S. Schroeder St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

August 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/10 19 27 to 8/18 19 27

that I last saw him alive on 8/18 19 27

and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic valvular

Heart dis (duration) Several yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) [illegible] M. D.

. 19 (Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial 8/20/27 19

20 UNDERTAKER [illegible]

ADDRESS 1003 W. Baltimore St

AUG 19 1927

RPR

OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

24876

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-201 E 24876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2143 Cambridge St. ST. 1-3 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Casimier J Pawlin

(a) RESIDENCE NO. 2143 Cambridge St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) McKeespart
(State or country) Pa.

PARENTS

10 NAME OF FATHER Alexander Pawlin

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Dziengielewski

13 BIRTHPLACE OF MOTHER (city or town) Stoben
(State or country) Ohio

14 Informant Alexander Pawlin
(Address) 2143 Cambridge St.

15 Filed ....., 19..... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1927, to Aug 19, 1927, that I last saw him alive on Aug 19, 1927, and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysed

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Rowell, M. D.

(Address) 501 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Aug.	20 1927

20 UNDERTAKER John M Weber ADDRESS 1003 Bank

TION IS very important. See instructions

Spec.—1-12-23—M&T—500 Blks.

attny 24/18 St Paul

E 24877 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24877

CERTIFICATE OF DEATH.

24-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2233 N. Calvert ST. 12-50 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Heald

(a) RESIDENCE NO. 2233 N. Calvert ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet A. Heald

6 DATE OF BIRTH (month, day, and year) Feb 15-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	58	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrical Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer Dept

(c) Name of employer B & O Ry. Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Heald

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Fowler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Harriet A. Heald (Address) 2233 N. Calvert St.

15 Filed ..... 19..... Registrar

AUG 19 1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1927, to Aug. 18, 1927, that I last saw him alive on Aug. 18, 1927 and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry B Athey, M. D.

8/19, 1927 (Address) 2504 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fremount Conn

DATE OF BURIAL Aug 20th 1927

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.—1-12-23—M&T—500 Blks.

Brown
1837 Pennsylvania

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24878

43 E 24878

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1503 Madison Ave (WARD) 14-20

2-FULL NAME Mary E. Walsh

(a) RESIDENCE NO. 1503 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of John W. Walsh

6 DATE OF BIRTH (month, day, and year) Jan 19 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	52	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Hugh Growney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Inman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Grace M. Walsh

(Address) 1503 Madison Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 6 1927 to Aug 18 1927

that I last saw h~~e~~alive on Aug 17 1927

and that death occurred, on the date stated above, at 10 A m

The CAUSE OF DEATH* was as follows:

Carcinoma Right Ear
(Inoperable)

(duration) 2 yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical Symptoms

(Signed) Jane Brown, M. D.

8/18, 1927 (Address) 1837 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 22 1927
20 UNDERTAKER Meliaire Cooke	ADDRESS 502 E North Ave

3 1927 C. HAMILTON JONES M.D.

Spec.—1-12-23—M&T—500 Bks.

Dr McIver 1303 N Eutaw

E 24879

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 24879

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2628 Maemples Lane ST., 20-24 WARD)

2-FULL NAME Ora Mary Lynch

(a) RESIDENCE NO. 2628 W. Maemples Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward J. Lynch

6 DATE OF BIRTH (month, day, and year) Feb 20, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	65	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Miss

PARENTS

10 NAME OF FATHER William Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Miss

14 Informant Edward J. Lynch

(Address) 2628 W. Maemples Lane

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1927

17 I HEREBY CERTIFY, That I attended deceased from July 16 , 1927 , to July 18 , 1927 ,

that I last saw h alive on July 18 , 1927

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible]

, 19 (Address) 1303 W. Eutaw , M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon	July 22 1927

20 UNDERTAKER W. M. Cook

ADDRESS 833 E. Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 24880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24880

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Carter's Donaldson Ave ST. Belvedere Terrace WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonora B. Patterson

(a) RESIDENCE NO. Roxbury - N.Y. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Capt. Wm M. Patterson

6 DATE OF BIRTH (month, day, and year) Jan. 4 1840

7 AGE 87

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
88	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm Paul Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Ellen Galloway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs. Leonora B. Broderick Glyndon Md

15 Filed 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1925 to Aug 18, 1927

that I last saw h[illegible] alive on Aug 18, 1927

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Ethmoiditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M.D.

Aug 19 27 (Address) 102 W. 20th St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Roxbury N.Y. DATE OF BURIAL Aug 20 1927

20 UNDERTAKER Wm J Pickerel Sons ADDRESS North Pa

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24881

CERTIFICATE OF DEATH

45 E 24881

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospital Street 22-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alta Hines Babcock

(a) RESIDENCE NO. 440½ Lakeland St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William R Babcock

6 DATE OF BIRTH (month, day, and year) September 29, 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	49	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio

(State or country)

PARENTS

10 NAME OF FATHER A. J. Hines

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Sarah E. Owens

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ohio

14 Informant Husband

(Address) 7402 Lakeland

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11 1927

17 I HEREBY CERTIFY, That I attended deceased from August 7, 1927, to August 11, 1927, that I last saw h.r alive on August 11, 1927, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Primary - Not Known Secondary

7

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystoitis & Chronic Intestinal Obstruction

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug. 7th 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — Date of Burial Aug 22 1927

20 UNDERTAKER Chas. H. Black — ADDRESS 742 W. Northam

OF DEATH in plain terms, as cause of death may be very important. See instructions on back of certificates.

C. HAMILTON JONES M.D.

1927

For

Spec.—1-10-21—M&T—1500 Bks.

E 24882 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 38 E 24882

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2531 Aisquith ST. 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine C. Howser

(a) RESIDENCE No. 2531 Aisquith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Howser

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Wm E. Lentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Barbara Berberich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Chas. E. Howser (Address) 2531 Aisquith St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 19 27, to Aug. 17, 19 27, that I last saw h er alive on Aug. 17, 19 27, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Post puerperal cardiac thrombosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis luetica

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. F. Hartman M. D.

8/19/19 27 (Address) 1 E. Randall st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 8/20 1927

20 UNDERTAKER J. E. Lahey & Son

ADDRESS 1318 Eutaw

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24883

CERTIFICATE OF DEATH.

E 24883

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1037 Brentwood Ave St. 11-15 Ward)

2-FULL NAME Jas J Cunningham

(a) RESIDENCE NO. 1037 Brentwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bridget Carthy

6 DATE OF BIRTH (month, day, and year): — — 1868

7 AGE: Years 59 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): Gas Co

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Jas Cunningham

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Welch

13 BIRTHPLACE OF MOTHER (City or town): Ireland

(State or country)

14 Informant: Bridget Cunningham

(Address) 1037 Brentwood Ave

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5 1927 to Aug 17, 1927

that I last saw h— alive on Aug 17, 1927

and that death occurred, on the date stated above, at 10-30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

& Mitral Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Epithelioma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R E L Cameron, M. D.

19 27 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bay View — Date of Burial 8/20 1927

20 UNDERTAKER: F. J. Tabaydow — ADDRESS 1316 Eutaw St

very important. See instructions on back of certificates.

CHARLTON [illegible] M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24884

CERTIFICATE OF DEATH.

170 E 24884

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 9 Ward)

2-FULL NAME Anton Belosky

(a) RESIDENCE NO. 436 N Pat Pl. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE: Years 19 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Navy Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balt

PARENTS

10 NAME OF FATHER Jos. Belosky

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balt

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt

14 Informant Effie Turner

(Address) 436 N Patterson Pk

15 Filed Aug 17 19 27 C. CHAMPION JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide

Gun Shot wound of Head

(Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) .....yrs. .....mos. .....ds.

Aug 19 27 (Signed) Gus Clinton Blades M. D.

(Coroner)

(Address) 143 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Aug 22 1927

20 UNDERTAKER: Enoch Croxton — ADDRESS: 1916 N Broad

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—

Cor.—12-9-25—A Co.—200 Bks. (Franciotti)

E 24885

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

E 24885

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital 10-15 St. Ward)

2-FULL NAME Filomena Franciotti

(a) RESIDENCE NO 1012 Hanover St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 22 1924

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Stefano Franciotti

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Edoarda Pellegrini

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Stefano Franciotti

(Address) 1012 Hanover St

15 Filed_____ 19_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Mac
Fracture Skull & Injuries

(duration) yrs. mos. dy.

CONTRIBUTORY (Secondary) Sick

(duration) yrs. mos. ds.

(Signed) G. E. Radcliffe M. D.

May 19 (Coroner) (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial May 21 19 27

20 UNDERTAKER Creek Creighton ADDRESS Maryland

Cor. Please fill out all items. Use ditto marks only when very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24886

E 24886

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH St. Joseph's Hosp

CITY OF BALTIMORE: (No.) 2-4 (Ward) (WASILEWSKA)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Josefina Wasilewska

(a) RESIDENCE NO. 616 S. Wolfe ST. S. T. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ladislaus

6 DATE OF BIRTH (month, day, and year): 1865.

7 AGE: Years 62 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer): Homework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Andrew Wasilewski (Address) 616 S. Wolfe St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): aug 18. 1927

17 I HEREBY CERTIFY, That I attended deceased from aug 12, 1927. to aug 18, 1927.

that I last saw her alive on aug 18, 1927.

and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of Peritoneum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of aug 13-1927.

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. Laurence Fahney M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus

DATE OF BURIAL: 8/22 1927

20 UNDERTAKER: William Fiaschowski

ADDRESS: 1618 Linden

1927 C. EAMON JONES M. D.

TION IS very important. See instructions on reverse side.

E 24887

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 113

E 24887

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Frazers

(a) RESIDENCE NO. 36 Silan St. Ward ~~City~~ Essex Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Wm Frazers

11 BIRTHPLACE OF FATHER (City or town) Md —
(State or country)

12 MAIDEN NAME OF MOTHER Elsie Hall

13 BIRTHPLACE OF MOTHER (city or town) Va —
(State or country)

14 Informant Records —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1927 to Aug 17 1927

that I last saw her alive on Aug 17 1927

and that death occurred, on the date stated above, at 8 35 P. m.

The CAUSE OF DEATH* was as follows:

Entero. colitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? 4 Silver Ave

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Carmel	8/20/1927
20 UNDERTAKER John G. Connelly	ADDRESS Essex Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIAN should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

AUG 19 1927

Spec.—1-12-23—M&T—500 Blks.

E 24888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 E 24888

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 335 Lynchwood (ST.) 20-19 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Hines Sr.

(a) RESIDENCE NO. 335 S. Lynchwood St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed or divorced HUSBAND of (or) WIFE of Ida C. McGinnis

6 DATE OF BIRTH (month, day, and year) Feb 15th 1859

7 AGE Years 67 Months 9 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gun Mender

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (City or town) (State or country) Ellis. Md.

PARENTS

10 NAME OF FATHER Martin Hines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Alice O Toole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Ida R Hines

(Address) 335 S. Lynchwood St

15 Filed Aug 20 1927 C. EDMUNDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1926 to Aug 18, 1927, that I last saw h— alive on Aug 17 1927, and that death occurred, on the date stated above, at 12 a. m.

The CAUSE OF DEATH* was as follows:

Art. Sclero.

Hypotension

(duration) when yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B. Fenny, M. D.

8/19 1927 (Address) 9.0 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lindenwald Park. DATE OF BURIAL Aug 20 1927

UNDERTAKER J. B. Wyatt ADDRESS 150 W Baltimore St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24889

E 24889

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO. 11124

City of BALTIMORE: (No. Baltimore City Hospitals (T St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Davis

(a) RESIDENCE NO. 130 Dolphin st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days
	28		

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Thomas

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Liza Matthews

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

C. Hampson Jones, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 August 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12, 19 27, to August 17 19 27,

that I last saw her alive on August 17 19 27,

and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Tuberculous enteritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. E. Madden M. D.

8-17. 1927 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Cem Aug 20 1927

20 UNDERTAKER — ADDRESS

Daniel Easton 916 Pa ave

1927

RRH

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24890

CERTIFICATE OF DEATH.

47 E 24890

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Harford Ave ST. 10-14 WARD)

2-FULL NAME Mary Ellen Murphy

(a) RESIDENCE NO. 1008 Harford Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Murphy

6 DATE OF BIRTH (month, day, and year) June 12 1899

7 AGE — Years: 28 — Months: 2 — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Patrick Clinton

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Wallace

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Elizabeth Clinton
(Address) 1008 Harford Ave

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1927, to Aug 19, 1927, that I last saw h[illegible] alive on Aug 15, 1927, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(duration) ..... yrs. 8 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of Jan 27

Was there an autopsy? No

What test confirmed diagnosis? Section of Breast

(Signed) D. W. Bernard Wood, M. D.

8/19, 1927 (Address) 914 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug. 22, 1927
20 UNDERTAKER	**ADDRESS**
Elmer W. Conklin	924 E. Eager St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24891

CERTIFICATE OF DEATH.

182 E 24891

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Pier 16 Light St. Wharf. St. 22-33 Ward)

2-FULL NAME Louis Holzworth.

(a) RESIDENCE NO. 738 Light St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): August 10, 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Quartermaster.

(b) General nature of industry, business, or establishment in which employed (or employer): Stmr. Express

(c) Name of employer: Tolchester Steamboat Co.

9 BIRTHPLACE (city or town) _____

(State or country): New Jersey.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country): Do not know.

14 Informant: Elizabeth Cubley.

(Address): 738 Light St.

15 Filed _____, 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 17, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from Stmr. Express.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Otto M. Hemsath M. D.

(Coroner)

8/19 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery Date of Burial: Aug 20 1927

20 UNDERTAKER: Margaret J. Fagan ADDRESS: 1422 Light St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24892

CERTIFICATE OF DEATH.

40 E 24892

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 132 Colvin 5-8 Ward)

2-FULL NAME James Rhodes

(a) RESIDENCE NO. 132 Colvin St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	5	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country)

14 Informant John H Watkins

(Address) 130 Colvin St

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry. find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dil. Heart

Duration (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

Duration (duration) ___ yrs. ___ mos. ___ ds.

Aug 19 Signed W. P. Reed M. D.

(Coroner)

, 19 27 (Address) 1697 Riverdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvery Cem. Date of Burial: 8/20 1927

20 UNDERTAKER: Brown & Wright ADDRESS 1218 Mc Elderry St

very important. See instructions on back of certificate.

8/20/1927 C. H. Wilson Jones M. D.

Spec.–7-17-26—A Co.—200 Bks.

E 24893

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24893

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 74001

City of BALTIMORE: (No. BALTIMORE CITY HOSP. St. 24-38 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Dorsey

(a) RESIDENCE NO. 1427 Weber St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year)

7 AGE Years: About 50 Months: Days: IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Not known

(State or country): Maryland

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (City or town):

(State or country)

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant

(Address)

15 Filed ..... 19 ..... Registrar

AUG 20 1927 C. HAMILTON JONES, M. D. Registrar

1631 ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-15 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-12, 1927, to 8-15, 1927,

that I last saw her alive on 8-15, 1927,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 0 ds.

CONTRIBUTORY (Secondary) Hypertention

(duration) ? yrs. mos. ds.

18 Where was disease contracted ?

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) C. Hamilton Jones, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem. Date of Burial 8/17/27

19

20 UNDERTAKER A. E. Gross ADDRESS 1412 N. Eden

OF DEATH in plain terms, so that it may be understood by very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24894

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24894

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Nelsen

(a) RESIDENCE NO. O'Donnell & 23 St. Ward City

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-21-27

7 AGE Years 1 Months Days 28 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER Headman Nelsen

11 BIRTHPLACE OF FATHER (City or town) Md —

(State or country)

12 MAIDEN NAME OF MOTHER Mami Jann

13 BIRTHPLACE OF MOTHER (city or town) Germ —

(State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 KKD Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1927, to Aug 19, 1927, that I last saw him alive on Aug 19, 1927, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Acute gastro - intestinal indigestion

Otitis media

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — Date of Burial 8/20 1927

20 UNDERTAKER Philip Hennig ADDRESS 2016 Orleans

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24895

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital

REGISTERED NO. 124

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 6-12 WARD)

2-FULL NAME Mr. Anton. Pollhammer

(a) RESIDENCE NO. 2326 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Pollhammer

6 DATE OF BIRTH (month, day, and year): 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: A. Pollhammer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frederick A. Pollhammer

(Address) 913 W. Laguna ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): aug 19 1927.

17 I HEREBY CERTIFY, That I attended deceased from aug 12, 1927, to aug 19, 1927,

that I last saw h~~im~~ alive on aug 19, 1927,

and that death occurred, on the date stated above, at 2 30 4 m.

The CAUSE OF DEATH* was as follows:

Bronco - pneumonia (3 days)

Chr Endocarditis

(duration) 3 yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of aug 13-27

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) H. Lawrence Feheney M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 8/22/27 19

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans St.

Spec.–7-17-26–A Co.—200 Bks.

E 24896

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 24896

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1717 Harlem Ave St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Beam

(a) RESIDENCE NO. 1717 Harlem Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 5 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Allen N. Beam

6 DATE OF BIRTH (month, day, and year) March 8, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	61	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Johnston Forney

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Frances Gibbons

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Allen N. Beam

(Address) 1717 Harlem Ave

15 Filed ....., 19 .....

Registrar RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19. 19 27

17 I HEREBY CERTIFY, That I attended deceased from June, 19 27, to Aug 19, 19 27,

that I last saw h alive on Aug 15, 19 27,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) L. M. Lampert, M. D.

Aug 20 1927 (Address) 3409 Callow Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Laurel Ridge May 22. 19 27

20 UNDERTAKER — ADDRESS

Arnold Mitchell & Sons Baltimore

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24897

CERTIFICATE OF DEATH.

1917 E 24897

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1502 Gough St., 3-4 (Ward)

2-FULL NAME Donna M Stortuy

(a) RESIDENCE NO. 1502 Gough St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1890

7 AGE: Years 37 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): md.

PARENTS

10 NAME OF FATHER: Charles Norris

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER: Alia Norris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Ella Norris

(Address) 1502 Gough St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17- 1917

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 10 ds.

(Signed) G Lades, M. D.

(Coroner)

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery Date of Burial Aug 21 19 21

20 UNDERTAKER: Jos. J. Kirchner ADDRESS 1413 Bway

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Blks.

E 24898 2

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 38 E 24898

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Mills

(a) RESIDENCE NO. 114 Valley Ave. St. Balto Ward 12a

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 25 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 3 2

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER John Mills

11 BIRTHPLACE OF FATHER (City or town) Md —

(State or country)

12 MAIDEN NAME OF MOTHER Mary Mills

13 BIRTHPLACE OF MOTHER (city or town) Md —

(State or country)

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19

Registrar

1635 RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to Dec 16, 1927, that I last saw him alive on Dec 16, 1927, and that death occurred, on the date stated above, at 12 05 A. m.

The CAUSE OF DEATH* was as follows:

Terminal bronchopneumonia c myocardial insufficiency, aortic insufficiency Syphilitic aortitis

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) Acute Gonorrhea.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann

(Signed) Lyman Mentz M. D.

8/20, 1928 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Each question must be answered in every certificate, or the certificate will be returned for correction. Use ink and write very important. See instructions on back of certificate.

Spec.-7-17-26-A C&C—200 Blks.

B 24899

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 24899

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 36-37 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Brown

(a) RESIDENCE NO. Colgate - Md - St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 8-14-27

7 AGE: Years | Months | Days | IF LESS than 1 day 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER Henry Brown

11 BIRTHPLACE OF FATHER (City or town) Florida

(State or country)

12 MAIDEN NAME OF MOTHER Amy Hyatt

13 BIRTHPLACE OF MOTHER (city or town) Ga —

(State or country)

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 19 27, to Aug 15, 19 27,

that I last saw her alive on Aug 15, 19 27,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V. E. Rythmany, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: State Anatomical Board

Date of Burial 19

20 UNDERTAKER

ADDRESS

of certificates. very important. See instructions on back of

JOHNS HOPKINS HOSPITAL C. EMERSON JONES, M.D. 1927 1633

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 24900

E 24900

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 Ashton St. Ward 27th) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Clopein

(a) RESIDENCE. No. 2114 Ashton St., 27th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 hrs. How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day 11 hrs. or min.
	X	X	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Clopein

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER [illegible] Long

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Wm Clopein
(Address) 2114 Ashton St

15 Filed Aug 20, 1927 H. LAMSON JONES, M. D., Registrar
Star AKS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1927, to Aug 19, 1927, that I last saw h[illegible] alive on Aug 18, 1927, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James H Kitzenberger M. D.

8/19 1927 (Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Aug 20 27

UNDERTAKER H. B. Wiseheart ADDRESS 850 W. Baltimore St

THION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24901 E 24901

CERTIFICATE OF DEATH

54 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. H-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Savage

(a) RESIDENCE NO. Yarbana, S. C. St. Ward;

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos F Savage

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE Years: 53 Months: Days: IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina (State or country)

PARENTS

10 NAME OF FATHER Elmon Troutman

11 BIRTHPLACE OF FATHER (City or town) North Carolina (State or country)

12 MAIDEN NAME OF MOTHER Louise Eagles

13 BIRTHPLACE OF MOTHER (city or town) North Carolina (State or country)

14 Informant Thos F Savage (Address) Yarboro N C

15 Filed ..... 19 ..... Registrar RKH

AUG 20 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/19/27 19

17 I HEREBY CERTIFY, That I attended deceased from 8/4 , 1927 to 8/19/27 , 19 , that I last saw her alive on 8/19/27 , 19 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? – Date of –

Was there an autopsy? –

What test confirmed diagnosis?

(Signed) J. S. Winstead, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Rocky Mount N C — Date of Burial 8/20 27

20 UNDERTAKER Forgett Turley Fulton Taylor — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Diseases peculiar to women, and those dangerous to life at childbirth, must be specified. Deaths from accident, suicide, or homicide must be very carefully reported. Physicians are requested to make returns of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24902 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24902

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Hollins ST. 18-29 WARD)

REGISTERED NO.

(If death occurred in a bospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Virginia Fox

(a) RESIDENCE No. 902 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Fox

6 DATE OF BIRTH (month, day, and year): Dec. 26, 1871

7 AGE: Years 55 56 | Months 7 | Days 23 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo W. Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Adelina Landeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mrs. Addie Rucker 902 Hollins St

15 Filed AUG 21 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 9, 1927 to Aug 19 1927

that I last saw her alive on Aug 19 1927

and that death occurred, on the date stated above, at 5.05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lyman S. Abbott M. D.

19 (Address) 1832 N. Carlin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. | DATE OF BURIAL: Aug 22 1927

20 UNDERTAKER: John J. Cowan & Son | ADDRESS: 901 Hollins St.

AUG 21 1927 H. HARRISON, M. D.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-02 E 24903

E 24903

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. ST. 6-10 WARD)

2-FULL NAME Mrs Laura D. Gardner.

(a) RESIDENCE NO. 713 N. Belnord Ave. ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Harry K. Gardner

6 DATE OF BIRTH (month, day, and year) April 13/61

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Henry Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hospital Records

(Address)

15 Filed AUG 21 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20th 1927

17

I HEREBY CERTIFY, That I attended deceased from 8-20-27, 19 , to 8-20-27, 19 ,

that I last saw her alive on 8-20-27, 19 ,

and that death occurred, on the date stated above, at 7:45 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 713 N Belnord Ave.

Did an operation precede death? yes Date of 8-20-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Treat Mitchell Hall, M.D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL Aug 23 1927

20 UNDERTAKER Philip Herring ADDRESS 2016 Orleans St

TION is very important. See instructions on back of certificate.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24904

CERTIFICATE OF DEATH

45 E 24904

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [illegible] St. 15-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Sellman

(a) RESIDENCE NO. 1330 Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, (Married), Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Sellman

6 DATE OF BIRTH (month, day, and year) December 18 63

7 AGE 64 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER John Sellman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Rachel ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant (Address) Wife 1330 Fremont

15 Filed [illegible], 19 [illegible] Registrar

AUG 21 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-17 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-x, 1927, to 8-17, 1927, that I last saw him alive on 8-17, 1927, and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ascending colon

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) C. Holmes Bufford, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Date of Burial [illegible], 19 27

20 UNDERTAKER: Eugene T. Brooks ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24905

CERTIFICATE OF DEATH.

90 E 24905

REGISTERED NO.

1-PLACE OF DEATH St Joseph Hosp.

CITY OF BALTIMORE: (No. 10-14 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gruninger

(a) RESIDENCE NO. 1235 Harford ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lift yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lotta Alice Feb 2 Grunniger

6 DATE OF BIRTH (month, day, and year) 86

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Grunninger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) John Grunninger 1235 Harford ave

15 Filed ____, 19__ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1927

17

I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to Aug 20, 1927, that I last saw h alive on Aug 20, 1927, and that death occurred, on the date stated above, at 5-55 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis,
Chr Myocarditis

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Lawrence Fahney, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Aug. 23 1927

20 UNDERTAKER George J. Rutter — ADDRESS 1735 Harford ave.

Spec.—12-9-25—A Co.—200 Bks.

E 24906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24906

1-PLACE OF DEATH

City of BALTIMORE: (No. 5 East Washington 25 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Laura Virginia Ford

(a) RESIDENCE NO. 5 E Washington Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 0 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm E. Ford

6 DATE OF BIRTH (month, day, and year): 11, 22, 1848

7 AGE — Years: 78 — Months: 8 — Days: 27 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto City

(State or country)

PARENTS

10 NAME OF FATHER: Wm E Everett

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: Jane Wooten

13 BIRTHPLACE OF MOTHER (city or town): Annapolis Md

(State or country)

14 Informant: Jas. Ford

(Address): 5 E Washington St

15 Filed ..... 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8.19. 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1926, to Aug 19, 1927, that I last saw h.. alive on Aug 19, 1927, and that death occurred, on the date stated above, at 5.05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Durlington, M. D.

8/19 1927 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem Date of Burial Aug 22 1927

20 UNDERTAKER: A. Evans ADDRESS: 38 E. Fort Ave

OF DEATH IS plain type, so that a copy may be made with very important. See instructions on back of certificates.

AUG 1 1927 BALTIMORE, MD.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24907

CERTIFICATE OF DEATH.

144

E 24907

REGISTERED NO.

1-PLACE OF DEATH:

City of BALTIMORE: (No. St Agnes Hospital St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Lehmuth

(a) RESIDENCE NO. Phelps Lane St. 20th Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed or divorced, BUSBAND of (or) WIFE of: Wm L. Lehmuth

6 DATE OF BIRTH (month, day, and year): Dec 5 - 1892

7 AGE: Years 35 yrs | Months 8 | Days 14 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Lancaster Pa

PARENTS

10 NAME OF FATHER Jno Widmeyer

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Lancaster Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Lancaster Pa

14 Informant: Wm L. Lehmuth

(Address) Phelps Lane

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

August 19, 1927

I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... 19 27, to 8-19, 1927,

that I last saw her alive on 8-19, 1927,

that death occurred, on the date stated above, at 2:00 a.m.

THE CAUSE OF DEATH* was as follows:

Post partum hemorrhage (Uter)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. J. Knapp, M. D.

8-19, 1927 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial Aug 22nd 1927

20 UNDERTAKER: F. B. Hufford ADDRESS: 150 W. Balto St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24908

CERTIFICATE OF DEATH.

185 E 24908

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 20th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Wippert.

(a) RESIDENCE NO. 1850 W. Baltimore St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. — mos. — ds. How long in U. S., if of foreign birth? 59 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: mary wippert.

6 DATE OF BIRTH (month, day, and year): August 7-18

7 AGE: Years 78 Months 4 Days 11

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Frederick Wippert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Zier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: F. S. Wippert

(Address): 1850 W. Baltimore St

15 Filed ..., 19 ... Registrar

AUG 21 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Aug 18, 1927.

That I last saw him alive on Aug 18, 1927.

and that death occurred, on the date stated above, at 7:55 P m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Accidental fall - fractured left wrist (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Examination

(Signed) Louis N. Tolin M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem.

DATE OF BURIAL: Aug 22nd 19 27

20 UNDERTAKER: W. M. Rentzel Sons & Co.

ADDRESS: Baltimore

Otho B. Thomas M.D. Coroner Aug 20 1927

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Dr. Hungerford

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24909

CERTIFICATE OF DEATH.

E 24909

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2227 Essex ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lora Louise Burwright

(a) RESIDENCE NO. 2227 Essex ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

TION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 1st 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	2	11	— 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas L. Burwright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Suffolk Va

12 MAIDEN NAME OF MOTHER Mildred Stafford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Thomas L. Burwright

(Address) 2227 Essex St

15 Filed ..... 1927 ..... Registrar RPJC.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20th 1927

17

I HEREBY CERTIFY, That I attended deceased from 8/14, 1927, to 8/20, 1927, that I last saw h[er] alive on 8/20, 1927, and that death occurred, on the date stated above, at 2.55 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Kidney

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) asthenia & heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of 1st July

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & progression

(Signed) Guy A. Thompson, M. D.

, 19 (Address) 16236 Bath Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Aug 23rd 1927

20 UNDERTAKER F. B. Wright — ADDRESS 1850 W. Baltimore St

1927 C. HAMILTON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24910

CERTIFICATE OF DEATH.

90 E 24910

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital S. 25-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Brother Alfred William A Drury

(a) RESIDENCE NO. Leonard Hall St Agnes Hosp Catonsville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 31, 1890

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
36	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Big Clifty Ky

(State or country)

PARENTS

10 NAME OF FATHER Warren Hilden Ellis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Kentucky

12 MAIDEN NAME OF MOTHER M. Colard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Kentucky

14 Informant Brother Alfred

(Address) Leonard Hall

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 8-20-27

17 I HEREBY CERTIFY, That I attended deceased from 8-14, 1927, to 8-20, 1927, that I last saw him alive on 8-20, 1927, and that death occurred, on the date stated above, at 1 35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease - Rheumatic type

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) A.J. Knapp., M. D.

8-20, 1927 (Address) Saint Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Cathedral Cemetery Aug 22 1927

20 UNDERTAKER ADDRESS

J. F. Flanagan & Co 703 Fremont

very important. See instructions on back of certificates.

AUG 21 1927 C. HAMILTON JOHNS, M. D.

Spec.—12-9-25—A Co.—200 Bks.

E 24911

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24911

E. 24911

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 4V-39 Harford Road St. 29-44 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Elizabeth Walters

(a) RESIDENCE NO 4V-39 Harford Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): aug 20 1927

7 AGE — Years | Months | Days | IF LESS than 1 day ✓ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) 4V 39 Harford Ave

(State or country) Baltimore md

10 NAME OF FATHER Samuel E Walters

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth A Busick

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md

14 Informant Samuel E Walters

(Address) 4V 39 Harford Ave

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 27, 19..... to Aug 21-27, 19....., that I last saw h.. alive on Aug 21-27, 19....., and that death occurred, on the date stated above, at 7 10 p.m.

The CAUSE OF DEATH* was as follows:

Protracted Coma

Intracranial Hemorrhage

(duration) ..... yrs. ..... mos. 1 da.

CONTRIBUTORY none

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Herrman, M. D.

Aug 21-27 (Address) 1710 E. 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial: Aug 22 1927

20 UNDERTAKER: Chas. G. Black ADDRESS: 742 W. Fayette

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24912

CERTIFICATE OF DEATH

31

E 24912

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Baltimore City Hospitals (St.) (Ward) 14-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William [redacted] Cook

(a) RESIDENCE NO. 520 Baker st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) Unknown 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electric Operator

(b) General nature of Industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER William Cook

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Nannie Lee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 22, 19 27 to August 18 19 27

that I last saw him alive on August 18, 19 27

and that death occurred, on the date stated above, at 4.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. G. Middleton, M. D.

8-18-27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Charlotte Co. Va	Aug 21 1927

20 UNDERTAKER Mrs P. A. Elliott

ADDRESS 1225 Ashland Av

OF DEATH in plain terms, so that it may be properly classified. Data, statement of occupation is very important. See instructions on back of certificates.

Cor.--12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24913 — CERTIFICATE OF DEATH. — **E 24913**

188-003

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Agnes Hosp St. 26-34 Ward

2-FULL NAME Frank Lynch

(a) RESIDENCE NO. 121 N. 10th St. Highland Town, Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theresa Lynch

6 DATE OF BIRTH (month, day and year): March 10 1896

7 AGE — Years: 31 — Months: 5 — Days: 9 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Fireman in

(b) General nature of industry, business, or establishment in which employed (or employer): Fire Dept

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Peter J. Lynch

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: — Betz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Theresa Lynch

(Address): 121 N. 10th St.

15 Filed....., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or investigation) thereon and from the evidence obtained by Investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Died from effects of a paralytic Stroke 24 hrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock - Struck by auto (duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D. (Coroner)

Aug 29th 1927 (Address) Curtis Bay, Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial: Aug 22, 1927

20 UNDERTAKER: H. C. Branning and Son ADDRESS: N. Schroeder

Of DEATH in plain language, giving name of disease, and not mode of dying, in every case. Filling up all the blanks is required by law. The physician or coroner should make a personal report of the case to the Health Department. Neatness and accuracy are very important. See instructions on back of certificate.

AUG 21 1927 C. HUNTON JONES, M.

Spec.—1-12-23—M&T—500 Blks.

Quinn

HEALTH DEPARTMENT—CITY OF BALTIMORE

202

E 24914

E 24914

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4100 Maplewood Avenue ST., 4-17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D. Quinn.

(a) RESIDENCE NO. 4100 Maplewood Avenue ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	--	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Quinn

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Agnes I. Stein

13 BIRTHPLACE OF MOTHER (city or town) Belair
(State or country) Maryland

14 Informant J. Louis Quinn
(Address) 4100 Maplewood Avenue

15 Filed ....., 19 .....
Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 , 19 27 , to ..... , 19 ..... ,
that I last saw h alive on Aug 20 , 19 27 ,
and that death occurred, on the date stated above, at 7 50 P m.

The CAUSE OF DEATH* was as follows:

(Cor.)

Accidental strangulation
+ broken neck

Immediate

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Johnston , M. D.

, 19 (Address) 4709 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 8/22 19 27

20 UNDERTAKER Merkyll Brooks & Sons — ADDRESS 505 Park Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24915

CERTIFICATE OF DEATH

90 E 24915

1-PLACE OF DEATH W

REGISTERED NO.

City of BALTIMORE: (No. 1422 Gilmore St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Manuel Talbott

(a) RESIDENCE NO. 1422 Gilmore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Talbott

6 DATE OF BIRTH (month, day, and year) 10-28 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	49	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Jno Talbott

11 BIRTHPLACE OF FATHER (City or town) (State or country) Carroll Co. Md

12 MAIDEN NAME OF MOTHER Hanna Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Md

14 Informant Narcisis Holland

(Address) 1429 Winchester St.

15 Filed ..... 19 ..... Registrar

AUG 22 1927

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20-27 19

17 I HEREBY CERTIFY, That I attended deceased from 6-25, 1927, to 8-20, 19 27,

that I last saw him alive on 8-20, 19 27,

and that death occurred, on the date stated above, at 10:25 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) unknown

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Jno P. Saunders M. D.

19 (Address) 1029 N Fulton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

Date of Burial Aug 23rd 19

20 UNDERTAKER A. Jones

ADDRESS N 1 S. Gilmore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24916

11-001

CERTIFICATE OF DEATH.

E 24916

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 N. Mount ST. 14-27 WARD)

2-FULL NAME Laura Kent

(a) RESIDENCE No. 530 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Kent

6 DATE OF BIRTH (month, day, and year) Nov 30, 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Arundel Co Md.

PARENTS

10 NAME OF FATHER Jacob Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Queen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William Kent

(Address) 530 N. Mount St

15 Filed Aug 23, 1927 H. H. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Aug 19, 1927, that I last saw h[illegible] alive on Aug 19, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Influenza & General Debility (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D Gutheusard, M. D.

8-20, 1927 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug 23, 1927

20 UNDERTAKER Mrs Kate R. Williams

ADDRESS 522 N Schroeder St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24917

129

E 24917

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp. St. 15-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lorelle Wharton Shafer

(a) RESIDENCE NO. 1801 Clifton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	36	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Practical Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER W. L. Wharton

11 BIRTHPLACE OF FATHER (City or town)

(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Emma Pierce

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New Jersey

14 Informant Mrs. Edmund W. Wharton

(Address) 1801 Clifton Ave.

15 Filed 19

AUG 22 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to Aug 21, 1927,

that I last saw her alive on Aug 21, 1927,

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. da.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Blood Chemistry Urinalysis.

(Signed) F. J. Daugherty, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlotte N. C. — Date of Burial Aug. 22 1927

20 UNDERTAKER Chas. E. Franck — ADDRESS 607 Madison Ave

OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24918

REGISTERED NO. 16-67 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1207 Longwood ST., (WARD)

2-FULL NAME William M. Smith

(a) RESIDENCE NO. 1207 Longwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine E. Smith

6 DATE OF BIRTH (month, day, and year) Dec 31st 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Butcher

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine M. Smith

(Address) 1207 Longwood St.

15 Filed ..... 19 ..... (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19th 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 1927, to Aug 19, 1927, that I last saw h[illegible] alive on Aug 17, 1927 and that death occurred, on the date stated above, at 7:20 a.m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Renal Disease

Senility

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Anemia & Terminal Pneumonia

(Duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. [illegible], M. D.

, 19 (Address) 3040 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 8/22 1927

20 UNDERTAKER Geo. Weber Son

ADDRESS 2523 Edmondson Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24919

CERTIFICATE OF DEATH.

74-201

E 24919

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 740 N Fayette St. 18-76 Ward)

2-FULL NAME Mollie O. Smithson

(a) RESIDENCE NO. 740 N. Fayette St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jason Smithson

6 DATE OF BIRTH (month, day, and year): Feb. 18. 1870

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
57	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Thomas Duff

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Jane Elliott

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Helen L. Smithson

(Address): Benton St.

15 Filed _____, 19____ For R M K Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, on July 19 find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Appendix

(duration) ____ yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) Colapsus

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) G. C. Slater (Coroner) M. D.

(Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — Date of Burial: Aug 22 1927

20 UNDERTAKER: H. Cook — ADDRESS: 502 E Monument

OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificate.

AUG 22 1927 C. HUMPHREYS, M.D.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24920

CERTIFICATE OF DEATH.

E 24920

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-37 Ward)

2-FULL NAME John C Harvey

(a) RESIDENCE NO. 301-S-13th St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine M Harvey

6 DATE OF BIRTH (month, day, and year) Feb 3 1895

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Cafe

(c) Name of employer Self

9 BIRTHPLACE (city or town) Pittsfield (State or country) Mass

PARENTS

10 NAME OF FATHER John C Harvey

11 BIRTHPLACE OF FATHER (city or town) ____ (State or country) Mass

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ____ (State or country) Mass

14 Informant Josephine Harvey (Address) 301 S 13th St

15 Filed ____ 19 ____ R W H Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1927

17 I HEREBY CERTIFY, That I held an Autopsy upon the remains described above, held an ____ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Gunshot Wound of Head (3rd Degree)

(Duration) Instt yrs. ____ mos. 6 hrs.

CONTRIBUTORY (Secondary) Shock

(Duration) ____ yrs. ____ mos. 6 hrs.

(Signed) G C Yates M. D. (Coroner)

Aug 20 1927 (Address) 143 W 13th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsfield Mass Date of Burial Aug 23 1927

20 UNDERTAKER H. M. Cook ADDRESS 502 E North Ave

Cut through or mutilation of certificate. Fold here. Do not detach. Embalmer's Record. Use indelible pencil. Fill in all blanks. Be sure to answer every question. Sign in full. Do not abbreviate. OF DEATH in plain terms, so that it may be properly classified. Punctuation and abbreviations are not necessary, but the answers must be clear and complete. Omissions cause unnecessary correspondence and delay. Typewriting is preferred. Every certificate must be filled out in ink or typewriting. Do not use lead pencil. Every certificate must be signed. Every certificate must be filed with the Registrar of the district in which the death occurred. Every certificate must be filed before the body is removed from the district. Every certificate must be filed before burial or removal from the city. Every certificate must be filed before cremation. Every certificate must be filed before the body is removed from the city

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24921

CERTIFICATE OF DEATH.

E 24921

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3305 Mulberry St St., 76-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Krause

(a) Residence No. 3305 Mulberry St St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: ~~Male~~ Female

4-COLOR OR RACE: White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH, (month, day and year) July 8 1927

7-AGE, yrs. 1 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS:

10-NAME OF FATHER William B. Krause

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Edna Steinmetz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

11-(Informant) Wm B Krauser

(Address) 3305 Mulberry St

15-Filed AUG 22 1927 G. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 21 1927

17-I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1927 to Aug. 21 1927 that I last saw h[illegible] alive on Aug. 21 1927 and that death occurred, on the date stated above, at 5 a m

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Andrew Rembowicz M. D.

8/21 1927 (Address) 3579 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Bachmans Cem — DATE OF BURIAL: Aug 22 1927

20-UNDERTAKER: John Ulrich — ADDRESS: 208 E Adams

instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24922

CERTIFICATE OF DEATH.

31

E 24922

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. J. H. Hospital St., 2-4 Ward)

2-FULL NAME Stanislaw Kruszka

(a) RESIDENCE NO. 707 S. Gray St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena

6 DATE OF BIRTH (month, day, and year): unknown 1888

7 AGE: Years 39 Months ____ Days ____ IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer): _____
(c) Name of employer: _____

9 BIRTHPLACE (city or town): _____
(State or country): Poland

PARENTS

10 NAME OF FATHER: Kasper Kicinski

11 BIRTHPLACE OF FATHER (city or town): _____
(State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): _____
(State or country): Poland

14 Informant: Hospital Record
(Address)

15 Filed Aug 22 1927 19 C. HAMILTON JONES, M. D. Registrar
By: R R H

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Syp. Pneumonia

(duration) 1 yrs. 2 mos. 27 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) 0 yrs. 2 mos. 1 ds.

Certified Aug 22 1927 (Coroner) C. Hamilton Jones M. D.

19 (Address) 143 N. Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former, or usual residence _____

18 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. Date of Burial Aug 27

20 UNDERTAKER: F. W. Ozazewski ADDRESS 1730 Eastern Ave

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Last Statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24923

CERTIFICATE OF DEATH.

E 24923

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 16-26 Ward)

REGISTERED NO. 186-003

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Edward Burke

(a) RESIDENCE NO. 856 West Fayette St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 29, 1906

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	20	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Hollins Market.

(c) Name of employer

9 BIRTHPLACE (city or town) Sparrows Point

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nimrod T. Burke

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Williamson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Nimrod T. Burke

(Address) 856 West Fayette St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20, 1927 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Injury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Amputation for Gas Gangrene

(duration) 4 hrs

CONTRIBUTORY (Secondary) Injured Foot (duration) yrs. mos. ds.

(Signed) J. C. Gadis M. D.

8/22 1927 (Coroner) (Address) 149 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs.. ....mos.. ....ds. In the State ....yrs.. ....mos.. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olive Cemetery, Roslyn Date of Burial 8/23/27

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Baltimore St

OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

AUG 22 1927

For Registrar

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24924

CERTIFICATE OF DEATH.

100-001

E 24924

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mun Hospital St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sand Smith

(a) RESIDENCE NO. 1054 Hillmore St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theresa Smith

6 DATE OF BIRTH (month, day, and year): Jan 22 - 1887

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
38	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore City

(State or country)

PARENTS

10 NAME OF FATHER: Charles E Smith

11 BIRTHPLACE OF FATHER (city or town): Germany.

(State or country)

12 MAIDEN NAME OF MOTHER: Emma Barber

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Emma Smith

(Address) 1126 Battery Ave

15 Filed.....19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 18 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

(duration) 2 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) H Lawson

(duration) yrs. mos. ds.

Aug 19 27 (Signed) G E Yates M. D.

(Coroner)

(Address) 4318 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leake Hill Date of Burial 8 29 27

20 UNDERTAKER: J Frew McCully ADDRESS 1126 Font Ave

OF DEATH in plain terms, so that it may be properly classified. Early statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24925 E 24925

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 N. Caroline ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E Lapouraille

(a) RESIDENCE NO. 1515 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/30/1857

7 AGE — Years: 69 Months: 9 Days: 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alfred P Lapouraille

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary B Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Alfred Lapouraille

(Address) 1515 N. Caroline Street

15 Filed AUG 22 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1927, to Aug 21, 1927,

that I last saw h[illegible] alive on Aug 21, 1927

and that death occurred, on the date stated above, at 11[illegible] P m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

8-22, 1927 (Address) 120 Virginia St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 8/24 1927

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

TION is very important—See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

205-667

o/Kucharczyk

90

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24926

REGISTERED NO. **E 24926**

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Kucharczyk

(a) RESIDENCE NO. 524 S. Ann St. Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Kucharczyk

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 65 Months Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Poland

(State or country)

PARENTS

10 NAME OF FATHER Andrew Kucharczyk

11 BIRTHPLACE OF FATHER (City or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... T. HARRISON JONES M. D. Registrar

Per .....

AUG 22 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1927, to Aug 20, 1927, that I last saw him alive on Aug 20, 1927, and that death occurred, on the date stated above, at 3 20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 0 yrs. 6 mos. 0 da.

CONTRIBUTORY (Secondary) Arteriosclerosis, Emphysema Chr. Bronchitis

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted → unknown

If not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical data

(Signed) Eyman Meyer, M. D.

8/20, 19 27 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetery — Date of Burial: Aug. 24 1927

20 UNDERTAKER: George A. Weber — ADDRESS: 2205 Bank St.

(OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 24927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51 ✓ E 24927

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 902 N. Port St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund G. Tabeling

(a) RESIDENCE NO. 902 N. Port St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 2 mos. 19 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mildred Tabeling

6 DATE OF BIRTH (month, day, and year) May 31 1894

7 AGE	Years	Months	Days
	33	2	19 20

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer) in Western District

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Gerhart Tabeling

11 BIRTHPLACE OF FATHER (City or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Kirstein

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) France

14 Informant Mrs. Mildred Tabeling

(Address) 902 N. Port St.

15 Filed ..... 19 ..... Registrar

AUG 22 1927 C. H. Pel

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16th, 1927, to Aug. 20, 1927,

that I last saw him alive on Aug 20, 1927,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

Fulminous Pneumonia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

8.21.27 (Address) 107 East West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — Date of Burial Aug 24 1927

20 UNDERTAKER Henry Hoech & Son — ADDRESS 1201 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24928

CERTIFICATE OF DEATH.

100-001

E 24928

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1625 Hinkley Place St., 8-17 Ward)

2-FULL NAME Nellie M. Dorsey

(a) RESIDENCE NO. 1625 Hinkley Pl. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 29 1926

7 AGE — Years: — Months: 8 — Days: 23 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Wm H Dorsey

11 BIRTHPLACE OF FATHER (city or town): Westminster Md

(State or country)

12 MAIDEN NAME OF MOTHER Ethel Packman

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant Wm H Dorsey

(Address) 1625 Hinkley Place

15 Filed..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY Bronchopneumonia

(Secondary)

Aug 21 (duration) yrs. mos. 4 ds.

(Signed) Geo Yates M. D.

(Coroner)

1927 (Address) 43 Rot Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Belair Md — Date of Burial: Aug 23 1927

20 UNDERTAKER: Robt J Lumsden — ADDRESS 1642 N Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24929

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

R. P. 31

E 24929

REGISTERED NO. C

CITY OF BALTIMORE: (No. 119 Keswick Rd. ST.) (WARD) 27-53

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel M. Bortner

(Residence in Baltimore: No. 119 Keswick St.; 60 yrs. 6 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Widower

6-DATE OF BIRTH, Feb 15, 1857
(Month) (Day) (Year)

7-AGE, 60 yrs. 6 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 215

9-BIRTHPLACE, (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Lewis S. Bortner

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Saundra Miller

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma M. Devion

(Address) 101 Keswick

15-

Filed AUG 22 1917 HAMPSON JONES, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8/12 1917, to 8/19 1917, that I saw him alive on Aug 19 1917, and that death occurred, on the date stated above, at 7-30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. D. Stuart M. D.

8/20, 1917 (Address) 5535 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Aug 22 1917.

20-UNDERTAKER C. LeRoy Stiffler ADDRESS 1357 Oak

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 24930

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 24930

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3323 Stafford ST. 10-70 WARD)

2-FULL NAME Emma Troyer

(a) RESIDENCE No. 3323 Stafford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Troyer

6 DATE OF BIRTH (month, day, and year) May 27 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Chenoweth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Virginia Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Theodore Troyer (Address) 3323 Stafford St

15 Filed ....., 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1927 to Aug 20, 1927.

that I last saw her alive on Aug 20, 1927

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cl. ap by

(Signed) Fred T. Kyper, M. D.

, 19 (Address) 3321 Fredericks Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL aug 23 1927

20 UNDERTAKER Chenoweth & Son — ADDRESS 3615 Eastern Ave

THIS is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24931

CERTIFICATE OF DEATH

129 ✓ E 24931

REGISTERED NO.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1523 Rigs ave St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jett

(a) RESIDENCE NO. 1523 Rigs ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nelson Jett

6 DATE OF BIRTH (month, day, and year): 1880 ?

7 AGE: Years 47 Months 5 Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: laundress

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town): unknown

(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): unknown

14 Informant: Nelson Jett

(Address): 1523 Rigs av

15 Filed AUG 2 1927 19 HARRY JAMES WARD Registrar

Per LKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-19 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-16, 1927, to 8-19, 1927, that I last saw her alive on 8-19, 1927, and that death occurred, on the date stated above, at 11:55 P m.

The CAUSE OF DEATH* was as follows:

Myo-carditis

(duration) yrs. 2 mos. 17 ds.

CONTRIBUTORY (Secondary): nephritis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? examination

(Signed) Dr. R. Saunders, M. D.

. 19 (Address) 1029 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery — Date of Burial: aug 29 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 1691 Mans st

Spec.-7-17-26—A Co.—200 Bks.

E 24932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

E 24932

28-65

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 4104 Ethland Ave.-W.Forest Park Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Abigail Edwards

(a) RESIDENCE NO. 4104 Ethland Ave.-W.Forest Park Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Octavius S.Edwards

6 DATE OF BIRTH (month, day, and year) Dec.22 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	48	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Hart,

(State or country) Mich.

PARENTS

10 NAME OF FATHER Jas. Edward Cutler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Michigan

12 MAIDEN NAME OF MOTHER Lepha Sargent

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Michigan

14 Informant Octavius S. Edwards

(Address) 4104 Ethland Ave.

15 Filed ..... 19.... C. HAMILTON JONES, M. D.

Per ..... Registrar

AUG 22 1927

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1927, to Aug. 19, 1927, that I last saw her alive on Aug. 19, 1927, and that death occurred, on the date stated above, at 4.25 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic Pneumonia

(duration) yrs. 2 mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Amerith Sorrell M. D.

19 (Address) 3705 Liberty Hts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn Cemetery	Aug 22 1927
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

Spec.–7-17-26—A Co.—200 Bks.

24933

HEALTH DEPARTMENT—CITY OF BALTIMORE

19-003

15 E 24933

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2832 W Lanvale St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Graner

(a) RESIDENCE NO. 2832 W Lanvale St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 16, 1927

7 AGE: Years — Months 2 Days 5 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Clarence H Graner

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth C West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Clarence H Graner

(Address) 2832 W Lanvale St

15 Filed AUG 22 1927 19 HAMSON JONES, M. D. Registrar

Per A P G

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-21 1927

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1927, to Aug 21, 1927

that I last saw he alive on Aug-20, 1927

and that death occurred, on the date stated above, at 7-15 A m.

The CAUSE OF DEATH* was as follows:

Spina Bifida

(duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) yrs. 1 mos. 5 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) E. Gill Hall, M. D.

. 19 (Address) 1631 E. North av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial AUG 22 1927

20 UNDERTAKER Geo W Littlez — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Timpano

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24934

CERTIFICATE OF DEATH.

E 24934

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pasqualina Timpano.

(a) RESIDENCE NO. 26 N. Streeper St. 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 22nd 1921

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	6	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Michael Timpano

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Concetta Cutrona

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Michael Timpano

(Address) 26 N. Streeper St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: (Over)

Acc Burns (2nd Degree)

(Duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY Acc'd

(Secondary)

(Duration) yrs. mos. 1 ds.

Aug 27 27 Signed) G E Yates M. D.

(Coroner)

19 (Address) 143 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer	Aug 24th 1927
20 UNDERTAKER	**ADDRESS**
Frank C. Pistone	2818 E Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24935

E 24935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1644 N. Washington St., 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Adolphus Musch

(a) RESIDENCE NO. 1644 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Musch

6 DATE OF BIRTH (month, day, and year) Aug 2nd 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	66	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Musch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Musch (Address) 1644 N. Washington St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1927, to Aug 18, 1927, that I last saw h[illegible] alive on Aug 18, 1927 and that death occurred, on the date stated above, at 10a. m.

The CAUSE OF DEATH* was as follows:

Edema Valvular disease of Heart. Contusion of Face (accidental)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Tabes — (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible], M. D.

8/19/27 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 8/22 1927

20 UNDERTAKER E. J. Fanning & Son — 1938 E. Lafayette — ADDRESS

TION is very important See instructions on back of certificates.

G 22 1927 P.M. (C. HAMPSON JONES, M. D.)

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24936

CERTIFICATE OF DEATH.

E 24936

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital (Street) (WARD) 2744

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Holland

(a) RESIDENCE NO. 18½ Southern Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Eastasia Holland

6 DATE OF BIRTH (month, day, and year): 1847

7 AGE: Years 80; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Eliza Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs James A. Lewis (Address) 18½ Southern ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-21-1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Aug 21, 1927, that I last saw him alive on Aug 21, 1927, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Laurence Fahrney M. D.

, 19 (Address) St. Joseph Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: Aug 24 1927

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 408 N Howard St

TION is very important. See instructions on back of certificates.

G 2 1927 C. HAMPSON JONES, M.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24937

CERTIFICATE OF DEATH

159-002

E 24937

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 231 S. Seventh St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Piccitelli

(a) RESIDENCE NO. 231 S Seventh St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): aug. 19 1927

7 AGE: Years | Months | Days: 2

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Paris Piccitelli

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Italy

12 MAIDEN NAME OF MOTHER: Adelina Turbaze

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Italy

14 Informant: Paris Piccitelli (Father)

(Address) 231 S. Seventh St.

15 Filed ..... 19 ..... Registrar

CHARLSON JONES, M.D.

AUG 22 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): aug. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/9, 19 27, to 8/21, 19 27, that I last saw h[illegible] alive on 8/20, 19 27, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Failure of Breathing

Oral Delivery

(duration) 1 yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 8/22, (Address) 3323 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem. Date of Burial: Aug 23 1927

20 UNDERTAKER: Tilly & Zeiler ADDRESS: 703 S. Wolfe St.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24938

CERTIFICATE OF DEATH.

E 24938

REGISTERED No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Georgian Court Apartments

CITY OF BALTIMORE: (No. Linden Ave & Brooks Lane ST., 13-59 WARD)

2-FULL NAME Arthur Johnson

(a) RESIDENCE No. Linden Ave & Brooks Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

TION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Johnson

6 DATE OF BIRTH (month, day, and year) May 13- 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	39	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Portsmouth (State or country) Va

PARENTS

10 NAME OF FATHER Robert Johnson

11 BIRTHPLACE OF FATHER (city or town) Hanover (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bettie Smith

13 BIRTHPLACE OF MOTHER (city or town) Portsmouth (State or country) Virginia

14 Informant Mary Johnson (Address) Georgian Court Apts.

15 Filed , 19 RLK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 9- , 1927, to Aug 21 , 1927, that I last saw he alive on Aug 20 , 1927 and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical Examination

(Signed) Paul Brown, M. D.

Aug 21, 1927 (Address) 1837 Jenna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashland Va — DATE OF BURIAL Aug 22- 1927

20 UNDERTAKER Dan Easton — ADDRESS 516 Cary

Cor.—12-9-25—A Co.—200 Bks.

E 24939 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 24939

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1024 Vine St. 18-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Holmes

(a) RESIDENCE NO. 1024 Vine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colrd

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE: 25 Years — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Wm Washington

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Holmes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Sarah Holmes

(Address) 1024 Vine St

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest or Inquiry) thereon and from the evidence obtained by said Inquest and Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. 7 mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

(Signed) Thos. B. Norton M. D.

(Coroner)

Aug 21st 1927 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

(Where was disease contracted, if not at place of death?)

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Aug 22 1927

20 UNDERTAKER David Easton ADDRESS 916 E Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Sp... Co.—200 Bks.

E 24940

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24940

CERTIFICATE OF DEATH

129

1-PLACE OF DEATH — REGISTERED NO. _____

City of BALTIMORE: (No. 1222 N. Parish St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Copeland

(a) RESIDENCE NO. 1222 Parish St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE — Years: 58 — Months — Days — IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Bath City

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Elizabeth Curry

(Address): 1212 Parish St

15 Filed ... 19 ... Registrar

AUG 22 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1927, to Aug 22, 1927, that I last saw her alive on Aug 21, 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Edema Nephritis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Org Disease Heart

(duration) yrs. mos. 14 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical History

(Signed) J. Jas. T. Hooper, M. D.

. 19 (Address) 862 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr Oliver Cem — Date of Burial: Aug 22 1927

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Pa ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Frisby

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

E 2494T

CERTIFICATE OF DEATH

E 2494T

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Frisby

(a) RESIDENCE NO. 1324 W Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Frisby

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE: 70 Years Months Days

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: James Frisby

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Williams

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Friends

(Address) [redacted] JOHNS HOPKINS HOSP.

15 Filed ....., 19.... Registrar

AUG 22 1927 P.M. RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 20 19 27

Aug 20

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 19 27, to Aug 20, 19 27,

that I last saw h[illegible] alive on Aug 20, 19 27,

and that death occurred, on the date stated above, at 5 [illegible] m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis & collapse due to bronchial obstruction

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis, Emphysema

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lyman Wentz, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Ct — Date of Burial: Aug 23 19 27

20 UNDERTAKER: J. H. Broom & Son — ADDRESS: [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 24942 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24942

CERTIFICATE OF DEATH.

161-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 So Exeter St. 3-5 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hoffman

(a) RESIDENCE NO. 29 So Exeter St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): August 20-27

7 AGE — Years: New Born. Months: ..... Days: ..... If LESS than 1 day, hrs. of ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: New Born

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Albert Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Gertrude Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant ..... (Address) .....

15 Filed ..... 19 ..... Per ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 20 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1927, to August 20, 1927, that I last saw him alive on August 20, 1927, and that death occurred, on the date stated above, at 11.20 m.

The CAUSE OF DEATH* was as follows: Infant Transverse presentation - Supportive Care for retarded fetal ..... (duration) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Postmortem History of infant ..... (duration) all yrs. things. from

Where was disease contracted if not at place of death? Still.

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph L. Valentine M. D.

(Address) 14 So Henry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: .....

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

90 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

2 1927

UNIVERSITY OF MARYLAND

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24943

CERTIFICATE OF DEATH

38 E 24943

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) Provident Hospital St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Russell

(a) RESIDENCE NO. 419 Druid Hill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 5 77

7 AGE: Years 39 Months 3 Days 12 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ballo. (State or country) Ind.

PARENTS

10 NAME OF FATHER: Elijah Russell

11 BIRTHPLACE OF FATHER (City or town) Ind (State or country)

12 MAIDEN NAME OF MOTHER: Nancy Russell

13 BIRTHPLACE OF MOTHER (city or town) Ind (State or country)

14 Informant: Elijah Russell (Address) 419 Druid Hill Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1927, to Aug 21, 1927, that I last saw h alive on Aug 20, 1927, and that death occurred, on the date stated above, at 5:00 A.m.

The CAUSE OF DEATH* was as follows:

Suppuration & Hydrocephalus

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Lues

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Signs.

(Signed) John W. Gamble M. D.

(Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial Aug 23 1927

20 UNDERTAKER: Samuel Stanley & Bro. ADDRESS: Baltimore

IMPORTANT: Answers to questions must be entirely complete and accurate, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Moore

E 24944 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24944

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 562 Mosher St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Amanda Moore.

(a) Residence No. 562 Mosher St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Thomas Moore

6-DATE OF BIRTH (month, day and year) Sept. 15- 87

7-AGE. 39 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), N. C.

PARENTS.

10-NAME OF FATHER. Jesse Edwards

11-BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.

12-MAIDEN NAME OF MOTHER. Alice Cowan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) N. C.

14- (Informant) Rena Moore

(Address) 562 Mosher St

15- Filed....., 192.....

C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 20-11 PM

17- I HEREBY CERTIFY, That I attended deceased from Aug 19th, 1927 to Aug 20th 1927, that I last saw her alive on Aug 19th 1927, and that death occurred, on the date stated above, at 11-P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Kenneth Evans M. D.

, 19 (Address) 2737 N Chester St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem DATE OF BURIAL. Aug 23 27

20-UNDERTAKER. Edward Stanley & Bro ADDRESS 378

In plain terms, so that anyone can understand. See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

E 24945

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24945

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Md. General Hosp. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvert Beckett

(a) RESIDENCE NO. Owens Mill, Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 33 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Calvert Beckett

6 DATE OF BIRTH (month, day, and year) December 3, 1906

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
20	21	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Jacob G. Beckett

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Gertrude Stanley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

C. HAMPSON JONES, M.D.

AUG 23 1927

RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1927, to August 19, 1927, that I last saw h.. alive on August 19th, 1927, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows: Appendicitis

Acute Peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 16 '27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas A Tompkins, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Aug. 23 '27

20 UNDERTAKER Edward Stanley ADDRESS 1 W Baltimore

IF DEATH OCCURRED IN A HOSPITAL OR INSTITUTION, the NAME should be stated HERE. PHYSICIANS should be very careful to see that the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24946 113 E 24946

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1411 Anchor St., 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Jones Jr

(a) RESIDENCE NO. 1411 Anchor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 3, 8, 1927

7 AGE — Years: — Months: 5 Days: 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Va

(State or country)

PARENTS

10 NAME OF FATHER Alfred Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lancaster Va

12 MAIDEN NAME OF MOTHER Virginia Slater

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lancaster Va

14 Informant Bud F. Slater

(Address) 1411 Anchor St

15 Filed ....., 19 ..... Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

8 21

17 I HEREBY CERTIFY, That I attended deceased from 8.20 1927, to 8.21 1927, that I last saw him alive on 8.21 1927, and that death occurred, on the date stated above, at 10. a m.

The CAUSE OF DEATH* was as follows:

Cholera Infantis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 4 hours ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. J. Purrington, M. D.

8.21 1927 (Address) 702 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hecmes, Md — Date of Burial: 8/23 1927

20 UNDERTAKER: Wm. J. Dickman Sons — ADDRESS: Pa' North

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24947

CERTIFICATE OF DEATH

E 24947.

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1712 Eutaw St. St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Schella

(a) RESIDENCE NO. Rhoads Club St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 1 mos. 16 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 5 1869

7 AGE: Years 58 Months 1 Days 17

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Baltimore Md

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Caroline Schella

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Hospital record

(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): aug 24 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1927, to Aug 24, 1927,

that I last saw h... alive on Aug 21, 1927,

and that death occurred, on the date stated above, at 1:15 m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chr.

1 (duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Cardiohypertrophy - dilatation

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm A Armstrong, M. D.

, 19 (Address) 1712 Eutaw St

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — Date of Burial: Aug 23 1927

20 UNDERTAKER: Wm J Tickner & Sons — ADDRESS: North Ave

THIS should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 24948 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 24948**

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1940 Linden Ave ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Eleazer Bass

(a) RESIDENCE. No. 1940 Linden Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wh	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Bass

6 DATE OF BIRTH (month, day, and year) unk

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
44	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sonneborn, Strauss

9 BIRTHPLACE (city or town) Chejien (State or country) Minsk, Russia

PARENTS

10 NAME OF FATHER Leonard Bass

11 BIRTHPLACE OF FATHER (city or town) Chedien (State or country) Minsk, Russia

12 MAIDEN NAME OF MOTHER Esther

13 BIRTHPLACE OF MOTHER (city or town) Chedin (State or country) Minsk Russia

14 Informant Hyman Bass (Address) 3215 Abel Avenue

15 Filed . 19 Registrar

C. HAMPSON JONES, M. D.

AUG 22 1927 Per: RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 3, 1927, to Aug. 22 1927, that I last saw him alive on Aug. 22 1927, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma - Urinary Bladder

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Metastasis - Pelvis - Evert.

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical + Laboratory Exam.

(Signed) Harry Jenden M. D.

Jr. 19 7 (Address) 1102 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westman Ceme Co. DATE OF BURIAL 8/23 1927

20 UNDERTAKER Jack Lewis 1439 E. Balt St ADDRESS

CAUSE OF DEATH must be properly classified. Statistical information is required in all cases. Every question on this certificate must be answered if it may be properly classified. Any additional information will be appreciated. Many questions are self-explanatory. Some of the items are not applicable to all cases. Use plain terms. Abbreviations should not be used. Do not write in the margin. Do not fold. Use typewriter or pen and ink. Write plainly. Do not use pencil. Be sure to sign and date certificate. Read carefully the instructions on back of certificates.

TION is very important. See instructions on

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24949 ✓ 199 E 24949

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Lilly Hospital St. 27-55 Ward)

2-FULL NAME Lorester B. Pugh

(a) RESIDENCE NO. 5508 High Gate Drive Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Pugh

6 DATE OF BIRTH (month, day, and year) July 12, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurateur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

10 NAME OF FATHER Wm. S. Pugh

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret J. Kelly

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Lillian Pugh

(Address) 5508 Highgate Drive

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1927

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Burns 3rd Degree 6 hrs

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 6 ds.

Aug 27 1927 (Signed) G C Yates M. D.

(Coroner)

(Address) 443 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial Aug 24 1927

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Pleasant St

OF DEATH very importa

In terms, so that it may be pr
See instructions on back of ce

AUG 27 1927 C. HAMPSON MD No 1256

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

24950 **E 24950**

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 902 N. Charles ST. 11-3 WARD)

2-FULL NAME Rebecca Frances Kennard

(a) RESIDENCE NO. 902 N. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Aug. 29, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac County Virginia

PARENTS

10 NAME OF FATHER Phillip Kennard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Nova T. Will

(Address) 902 N. Charles St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Aug 22, 1927, that I last saw h alive on Aug 22, 1927 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Obstruction of Bowels

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Standish McClung, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tuley, Accomac Co., Va.

DATE OF BURIAL 8/23 19 27

20 UNDERTAKER Henry W. Dears & Son

ADDRESS 802 N. Calvert

TION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 24951 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 24951**

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2201 E Pratt St. St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Albers

(a) Residence No. 2201 E Pratt St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 10 1863

7-AGE.	If LESS than 1 day,
65 yrs. 5 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Poland

PARENTS

10-NAME OF FATHER, Andrew Albers

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Poland

11 (Informant) John Albers

(Address) 66 2201 E Pratt St.

15- Filed 1927 C. HARRISON JONES, M.D. Registrar.

In plain terms, so that it may be properly coded. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 21-1927

I HEREBY CERTIFY, That I attended deceased from July 27 19 27 to Aug 21 19 27

that I last saw her alive on Aug 21 19 27

and that death occurred, on the date stated above, at 9:35 A m.

The CAUSE OF DEATH* was as follows:

Chr Valvular Heart Disease

Chr. Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocardial Weakness acute

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Grace L. Fauntleroy M. D.

8/22, 1927 (Address) 4007 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Pikesville Laurel Hill Cem	24 19 27

20-UNDERTAKER. John M. Welker & Son

ADDRESS 803 Bond

Cor.—12-9-25—A Co.—200 Bks.

Goscinski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24952

CERTIFICATE OF DEATH.

E 24952

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2220 Fleet St. St., 1-3 Ward)

2-FULL NAME Joseph Goscinski

(a) RESIDENCE NO. 2220 Fleet St. St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Goscinski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Julia Goscinski

(Address) 2220 Fleet ST.

15 Filed_____, 19_____ ARH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Exhaustion

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

Signed) G. C. Yades M. D.

(Coroner)

19 (Address) 143 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Date of Burial Aug. 23 19 27

20 UNDERTAKER Adam Weber ADDRESS 1803 Bond

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 24953

Leduc

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 24953

CERTIFICATE OF DEATH.

16-002

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 2523 E Hoffman St. St. 8-16 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A Leduc

(a) RESIDENCE NO. 2523 E Hoffman St. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12 1927

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph A Leduc

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Manchuge Mass.

12 MAIDEN NAME OF MOTHER Bertha Howard

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Howard Co.

14 Informant Joseph A Leduc

(Address) 2523 E Hoffman St.

15 Filed _____ 19 _____ Registrar

2 2 1927 RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug 22 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20 19 27 August 22 19 27.

that I last saw him alive on August 21 19 27

and that death occurred, on the date stated above, at 1.45 a.m.

The CAUSE OF DEATH* was as follows:

Uterocolitis

(Duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ____ yrs. ____ mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Physical Examination

(Signed) Albert Abrams M. D.

8/22, 1927. (Address) 2025 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Holy Redeemer Cem 23 19 27

20 UNDERTAKER ADDRESS

John C. Miller 2435 E Eleven Ave

Be sure the cause is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24954

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Eagle St. 20-12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME William Richard Edlery

(a) RESIDENCE No. 2120 Eagle St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): April 3 1925

7 AGE: Years 2 Months 4 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Clifton Edlery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Spa

12 MAIDEN NAME OF MOTHER: Delma Wingate

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Clifton Edlery

(Address)

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to Aug 22, 1927

that I last saw him alive on 8-22, 1927

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Meningitis

(Probably pneumococcic)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Pulmonary abscess

Certificate 6 wks. yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What confirmation of diagnosis Clinical + Physical

(Signed) James Bryant M.D.

19 (Address) 808 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: Aug 23 1927

20 UNDERTAKER: Kenworth + Son

ADDRESS: 3656 Hartsdale ave

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24955

CERTIFICATE OF DEATH.

E 24955

1-PLACE OF DEATH
City of BALTIMORE: (No. On the way to the South Baltimore General Hospital Ward)

REGISTERED NO. 29534 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Wolf.

(a) RESIDENCE NO. 1742 Light St. St. Ward
(Usual place of abode)
Length of residence in city or town where death occurred 55 yrs. 10 mos. 21 ds. (If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) September 30, 1871.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55	10	20 21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Wolf.
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.
12 MAIDEN NAME OF MOTHER Margaret Stocket
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Ida L. Wolf. (sister)
(Address) 1436 Riverside Ave.

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.
(Coroner)

8/22, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former residence

19 Date of Burial

20 UNDERTAKER ADDRESS

2 1927 RCS

Don should be exactly supplied. Any doubt should be explained. Physician should state if DEATH occurred from any OCCUPATION in which he is engaged. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 24956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 24956

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1945 Patterson Place St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Miller

(a) RESIDENCE NO. 1945 Patterson Place St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Miller

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Canada

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Clara E. Miller

(Address) 1711 N. Montford Ave.

15 Filed AUG 23 1927 H. [illegible] JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1927, to Aug 22, 1927

that I last saw h alive on Aug 22, 1927

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 1503 W. Lombard

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Angel Hill Cemetery Havre de Grace - Md Via Auto — Date of Burial Aug 25 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Billiph. 2224 W. Lanvale

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 24957

1-PLACE OF DEATH E 24957.

REGISTERED NO.

CITY OF BALTIMORE: (No. 1626 Eleanor Ln. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Washington Thompson

(a) RESIDENCE NO. 1626 Eleanor Ln. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Fiola

6 DATE OF BIRTH (month, day, and year) Feb. 22 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real estate -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto -

PARENTS

10 NAME OF FATHER George Washington Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Sarah S Marden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mamie F. Thompson (Address) 1626 Eleanor Ln

15 Filed ..., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 19..., to Aug 21, 1927,

that I last saw h.. alive on Aug 21, 1927,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage from lung

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) Geo Billings, M. D.

, 19 (Address) 22 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge - Lot	23 1927
20 UNDERTAKER	ADDRESS
H. M. Cook	502 East Lan

CAUSE OF DEATH in plain terms, so that it may be properly classified. PARTICULAR ATTENTION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24958

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74-001

E 24958

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. City Hospital St. 23-31 Ward)

2-FULL NAME Maxie Jones

(a) RESIDENCE NO. 936 Hanover St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Jones

6 DATE OF BIRTH (month, day, and year) Feb. 15. 1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	33	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Byron L Bradley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Clara Petty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Clara Bradley

(Address) 1215 E Chase St

15 Filed AUG 23 1927 H. [illegible] M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

Duration ..... yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

Duration ..... yrs. 1 mos. ds.

Signed ..... M. D.

(Coroner)

, 19 (Address) 1431 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial Aug. 25 1927

20 UNDERTAKER H. Cook ADDRESS 302 E North Ave.

tion should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24959

CERTIFICATE OF DEATH

E 24959

REGISTERED NO. 57

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

City of BALTIMORE: (N[redacted] St. 10-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Cooper

(a) RESIDENCE NO. 720 Green mount ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John M. Cooper

6 DATE OF BIRTH (month, day, and year): 1853

7 AGE: 73 Years 7 4 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Sullivan

11 BIRTHPLACE OF FATHER (City or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Nora

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: John M. Cooper

(Address): 720 Greenmount Ave

15 Filed AUG 23 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 21 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-17, 1927, to 8-21, 1927, that I last saw h[illegible] alive on 8-21, 1927 and that death occurred, on the date stated above, at 4 45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

Bronchio-pneumonia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertention & Arteriosclerosis

Diabetes mellitus

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) C. Holmes Bunge, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State [redacted] m Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Grave.

Date of Burial: Aug 23 1927

20 UNDERTAKER: William Cook

ADDRESS: 324 E Watt

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24960

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24960

CERTIFICATE OF DEATH.

123

E 24960

1-PLACE OF DEATH St. Joseph Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 7-12 WARD)

2-FULL NAME Mrs Mary Pisarcik (Married)

(a) RESIDENCE NO. 2406 Ashland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Pisarcik.

6 DATE OF BIRTH (month, day, and year) Dec 5 1864.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	8 mths.	14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia.

PARENTS

10 NAME OF FATHER Not. known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia.

12 MAIDEN NAME OF MOTHER Not known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia.

14 Informant Mrs. Anna Svitak.

(Address) 2406 E. Ashland Ave.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 4 , 1927, to Aug 22 , 1927, that I last saw her alive on Aug 22 , 1927, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Chronic Nephritis (Primary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Aug 7.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Laurence Fleming, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery. DATE OF BURIAL Aug 25, 1927.

20 UNDERTAKER August Pasek. ADDRESS 2406 E Ashland Ave.

CAUSES OF DEATH: Please print plainly. See instructions on back of certificates. TION is very important

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24961

CERTIFICATE OF DEATH.

129 E 24961

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 10 Hooper Ave ST. 27-54 WARD)

2-FULL NAME Ida K Daily

(a) RESIDENCE NO. 10 Hooper Ave ST. Washington WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Jesse Daily

6 DATE OF BIRTH (month, day, and year) June 16 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elmer L Daily

(Address) 10 Hooper Ave

15 Filed AUG 25 1927 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1926, to Aug 21, 1927, that I last saw her alive on Aug 21, 1927 and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease Interstitial Regurgitation - Gentle Dilatation of Heart - Edema of Lungs (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C H Beelen, M. D.

8-22 1927 (Address) 102 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem, Balto. Co., Md.

DATE OF BURIAL Aug 24 1927

20 UNDERTAKER Wm C Brooks

ADDRESS Sparks, Md.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24962

CERTIFICATE OF DEATH.

90

E 24962
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 N. Douglas ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew McCaloop.

(a) RESIDENCE No. 1713 N. Douglas ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Balto Copper works

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Jackson McCaloop

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Hattie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Glenn Fenison
(Address) 1713 N. Douglas

15 Filed ..... 19 .....
AUG 23 1927 C. HAMILTON JONES, M.D.
Registrar

CAUSE OF DEATH to plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20- 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-9- , 1927, to 8-20- , 1927, that I last saw h alive on 8-20 , 1927 and that death occurred, on the date stated above, at 8-P. m.

The CAUSE OF DEATH* was as follows:

Valvulitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. T. Granger, M. D.

8-22-1927 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elliott. N. C

DATE OF BURIAL Augst 1927

20 UNDERTAKER John W Henderson

ADDRESS 1603 E. monument

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓

E 24963

REGISTERED NO.

E 24963

1-PLACE OF DEATH

City of BALTIMORE: (No. 108 Aisquith St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Hudgins

(a) RESIDENCE NO. 108 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Hudgins

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 43 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Petersburg

(State or country): Va.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): unknown

14 Informant: Mary Hudgins

(Address): 108 Aisquith St.

15 Filed ..... 19 ..... Registrar

AUG 25 1927 Per R. M. Jones

G. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 21 1927

17

I HEREBY CERTIFY, That I attended deceased from June 29, 1927, to Aug 21, 1927, that I last saw h.e. alive on Aug 20, 1927, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Endocarditis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Toxemia

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sp

(Signed) A. Edwards Fisher, M. D.

8-23 1927 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashury Cemetery Date of Burial Aug 24 1927

20 UNDERTAKER: Chas. H. Johnson ADDRESS 416 N. Carolina St.

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24964

CERTIFICATE OF DEATH.

46

E 24964

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital 15-58 St., Ward)

2-FULL NAME Mrs ~~Sam~~ Esther Cohen

(a) RESIDENCE NO. 3736 Reisterstown Rd. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Cohen

6 DATE OF BIRTH (month, day, and year): Sept. 13, 1887

7 AGE — Years: 39 — Months: 11 — Days: 9 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Russia

PARENTS

10 NAME OF FATHER: Morris Jacobstein

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Rivka —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Russia

14 Informant: Mrs. Samuel Cohen

(Address) 3736 Reisterstown Rd

15 Filed ..... 19.. Registrar

AUG 23 1927 BALTIMORE MD.

Per RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug 22, 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to Aug 22, 1927, that I last saw her alive on Aug 22, 1927, and that death occurred, on the date stated above, at 6.20 p. m.

The CAUSE OF DEATH* was as follows:

Malignant papilloma of bladder

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 15, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Philip Hartstone, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. Date of Burial 8/23/1927

20 UNDERTAKER: Abid Sondheim ADDRESS 118-20 W. Mt Royal Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24965

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 24965

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7158 Bethel ST. 2-d WARD)

2-FULL NAME Mary Nietzowska

(a) RESIDENCE NO. 7158 Bethel ST., ... WARD ...
(Usual place of abode)
(If non-resident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 60 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 15 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Eva Nietzowska
(Address) 715 S Bethel

15 Filed AUG 3 1927, 19 ... R M C Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to Aug. 22, 1927, that I last saw h[er] alive on Aug. 5, 1927 and that death occurred, on the date stated above, at 11.20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) about 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) G. T. Ries, M. D.

Aug 24 1927 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Aug 24 1927
20 UNDERTAKER	ADDRESS
Wendel & Duffy & Son	378 N

CAUSE OF DEATH to plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24966

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915 Brunt ST. 14-20 WARD)

2-FULL NAME Fannie Harriett Herried

(a) RESIDENCE No. 1915 Brunt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Herried

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: Years 54 Months — Days —

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 641

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Caroline Co Va

PARENTS

10 NAME OF FATHER: Horace Dotson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Kelly Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Nannie Scott 502 N Franklin St

15 Filed AUG 23 1927, 19 Registrar: RWH

RAYMOND JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1927, to Aug 20, 1927, that I last saw her alive on Aug 20, 1927, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH was as follows:

Carcinoma Mediastine

(duration) Unknown

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W F Howell M. D.

(Address) 119 N Carrollton Ave

[State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Aug 23 27

20 UNDERTAKER: Samuel H Hensley

ADDRESS 1118 Eddie

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24967

CERTIFICATE OF DEATH.

113

E 24967

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1119 Carson Court Ward 23)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Miles

(a) RESIDENCE NO. 1119 Carson Court Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 19-27

7 AGE: Years 3 Months 2 Days 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Henry Miles

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Ethel Turner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Ethel Turner Miles

(Address) 1119 Carson St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 19, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Colitis

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary): no history

(duration) .....yrs. .....mos. .....ds.

(Signed) D. T. Hennessy M. D.

(Coroner)

Aug 22 1927 (Address) 1401 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial

Mt. Olivet Cem Aug 23 1927

UNDERTAKER: Thos E. Nelson ADDRESS 1128 E Baltimore St

AUG 1927 HAMPTON JONES, M.D.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24968

CERTIFICATE OF DEATH.

38 E 24968

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Hogarty

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	Unknown		

8 OCCUPATION OF DECEASED (Maid)

(a) Trade, profession or particular kind of work House Work.

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Unknown Ireland

PARENTS

10 NAME OF FATHER John Hogarty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tuam Galway Ireland

12 MAIDEN NAME OF MOTHER Mary O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Galway Ireland

14 Informant (Address) Mt Hope Friends Mt Hope Retreat

15 Filed ....., 19 ..... Registrar R H Lee

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1927, to Aug 21, 1927,

that I last saw h alive on Aug 21, 1927,

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Paretic Dementia.

(Cerebro-Spinal Syphilis)

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Depression Psychosis

(duration) yrs. 9 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Serological

(Signed) Milton P. Hill, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL August 24th 1927

20 UNDERTAKER Mary M. Wedeles ADDRESS 501 E 22

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24969 +3 E 24969

E 24969
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO.

CITY OF BALTIMORE: (No. 3501 Grantspring Ave St. 43-57 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lemuel H. Dyott

(a) RESIDENCE. NO. 3501 Grantspring Ave St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Agnes V. Dyott

6 DATE OF BIRTH (month, day, and year) July 22-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	-1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) — Inspector

(c) Name of employer Shipping Board

9 BIRTHPLACE (city or town) (State or country) — Balto Md

PARENTS

10 NAME OF FATHER Marion A. Dyott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Meredith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Agnes V. Dyott
(Address) 3501 Grantspring ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3 . 1927, to Aug 22 . 1927, that I last saw h alive on Aug 22 . 1927, and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma (Endothelioma) ovary

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. F. Wheeler, M. D.

8/22, 19 27 (Address) 1299 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Cross Phila Pa — DATE OF BURIAL — Phila Pa Aug 24, 1927

20 UNDERTAKER — H. Brannigan Sons & Schnerdt — ADDRESS 517 N

REGISTERED NUMBER SHOULD BE GIVEN IN CASE OF STILLBIRTH. AGE Should Be Stated EXACTLY. PHYSICIANS Should Make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 23 1927

Spec.–7-17-26—A Co.—200 Bks.

205 E 24970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 24970

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPIT. St. 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Allender

(a) RESIDENCE NO. 1011 N. Chapel St. Ward City

(Usual place of abode)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-25-27

7 AGE Years Months 6 Days 26 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Ernest Allender

11 BIRTHPLACE OF FATHER (City or town) Md —
(State or country)

12 MAIDEN NAME OF MOTHER Marion Sharp

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C.
(State or country)

14 Informant Records —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 29 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1927, to Aug 21, 1927, that I last saw him alive on Aug 21, 1927, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Acute G-I Indigestion

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Congenital Syphilis. Otitis Media

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E E Rathbun, M. D.

19 (Address) by Dr Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Laurel Cemetery	Aug 23 1927
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS Laurel Md

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24971

CERTIFICATE OF DEATH.

114 ✓

E 24971

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1537 Myrtle Ave W. 20 St. Ward)

2-FULL NAME Wm. Rinehart

(a) RESIDENCE NO. 1537 Myrtle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Color

5 Single, Married, Widowed, or Divorced. (Write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 25, 1911

7 AGE: Years 15 Months 7 Days 26 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Wash. D.C.

(State or country)

PARENTS

10 NAME OF FATHER Irving Rinehart

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md.

12 MAIDEN NAME OF MOTHER Irene Jacobs

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant Irene Rinehart

(Address) 1537 Myrtle Ave

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) acute bronchitis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Kinney M. D.

(Coroner)

19 27 (Address) 2512 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cemetery Date of Burial Aug 2 1927

20 UNDERTAKER: Leonard Whaley ADDRESS 308 Myrtle Ave

AUG 25 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24972

CERTIFICATE OF DEATH.

161-001

E 24972
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. J. H. Hospital, St., 76-27 Ward)

2-FULL NAME Tony Licone

(a) RESIDENCE NO. 3922 Clairmont St. 26 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 20 1927.

7 AGE — Years — Months — Days: 2 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Licone

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy.

12 MAIDEN NAME OF MOTHER Cecilia Verra

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Edward Licone
(Address) 3922 Clairmont Ave

15 Filed ..... 19 ..... R.H.J. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Premature Birth

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. 1 ds.

(Signed) G. C. Radu M. D.
(Coroner)

Aug 23/27 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dale Lawn Cem. — Date of Burial: aug 25 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Mosher St

N. B.—WRITE PLAINLY, with pen and ink. Every question should be carefully answered. If unknown, so state. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 23 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24978

CERTIFICATE OF DEATH.

112

E 24973
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1211 Chatsworth St., 8-13 Ward)

2-FULL NAME Emmett Knight

(a) RESIDENCE NO. 1211 Chatsworth St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bettie Knight

6 DATE OF BIRTH (month, day, and year) June 6 1881

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Western Md Dairy

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Robert Knight

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Washington

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Bettie Knight
(Address) 1211 Chatsworth

15 Filed AUG 23 1927 19 C. H. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

AC Indigestion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

(duration) yrs. mos. 1 ds.

Signed) P C Yates M. D.
(Coroner)

19 (Address) 1438 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial Aug 23 1927

20 UNDERTAKER Mac R. C. Elliott ADDRESS 1725 Oakland Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24974

CERTIFICATE OF DEATH.

51 E 24974

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. J. H. Hospital St. 1-22 Ward)

2-FULL NAME Sarah Offer.

(a) RESIDENCE NO. 1515 Mosher St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced,, (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8-21

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	6	-	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Lawrence Offer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Lawrence Offer

(Address) 1515 Mosher

15 Filed ..... 19 .....

AUG 23 1927 C. HENRY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1927

17 I HEREBY CERTIFY, That I visited the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) 1 yrs. mos. ds.

Aug 23/27 (Signed) G. C. Hades M. D.

(Address) 1431 Division St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial Aug 25 19 27

20 UNDERTAKER Sam T. Chase ADDRESS [illegible]

I hereby certify that the above is correct to the best of my knowledge and belief.

Physician or Coroner.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 24975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 24975 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 E. Mongomery St. 22-33 Ward)

2-FULL NAME John A. Gier

(a) RESIDENCE NO. 109 E Mongomery St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1st 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Emil Cage.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Charles Gier

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Frances Hardy

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

14 Informant Mrs Frances Gier

(Address) 109 E. Mongomery St.

15 Filed AUG 23 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 21 1927, to Aug 22, 1927 that I last saw him alive on Aug 21, 1927, and that death occurred, on the date stated above, at 2.30 A.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation.

(Signed) E. I. Bouchelle, M. D.

, 19 (Address) 2104 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Western Cemetery Aug 24 1927

20 UNDERTAKER ADDRESS

Margaret H. Flynn 1422 Light

e stated EXACTLY. PHYSICIANS should state CAUSE
properly classified. Exact statement of OCCUPATION is
certificates.
tion should be carefully supplied. AGE should be stat
OF DEATH in plain terms, so that it may be properl
very important. See instructions on back of certifica

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

H 024976 — E 24976

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Scardino

(a) RESIDENCE NO. 3470 Mt. Pleasant St. Ward 10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 27 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 27 1927

7 AGE Years: 0 Months: 5 Days: 27 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER James Scardino

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Pinkney

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country) Baltimore

14 Informant: Records

(Address) Johns Hopkins Hospital

15 Filed AUG 23 1927 By RPA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1927, to Aug 22, 1927, that I last saw h[illegible] alive on Aug 22, 1927, and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. 13 mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos 13 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. C. Rotton, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery Date of Burial 24 1927

20 UNDERTAKER: John J. Bowan & Son ADDRESS 901 Hollins St

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24977

CERTIFICATE OF DEATH.

E 24977

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 820 N. Parrish St. 16-22 Ward)

2-FULL NAME George Laurel

(a) RESIDENCE NO. 820 N. Parrish St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Carey

6 DATE OF BIRTH (month, day, and year): about 1873

7 AGE — Years: 54 — Months — Days — IF LESS than 1 day....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry business, or establishment in which employed (or employer): General

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Henry Laurel

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Cooley

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Annie Gant

(Address) 820 N. Parrish St.

15 Filed....19.... C. HILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 16 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) no other trouble

(duration) ....yrs. ....mos. ....ds.

(Signed) C. H. Jones M. D.

(Coroner)

19 27 (Address) 250 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

N. B.—WHITE PAPER, WITH BLACK INK, MUST BE USED. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24978

CERTIFICATE OF DEATH.

E 24978

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mun Hospital St. 4-25 Ward)

2-FULL NAME H A K Bos.

(a) RESIDENCE NO. 570 N. Fayette St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 65 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed ..... 19 .....

Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Gun Shots of Head

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY Shocks

(Secondary)

(duration) ..... yrs. ..... mos. 1 ds.

aug (Signed) G. C. Hades, M. D.

23 27 (Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Entry of each item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

24979 5-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37-01 E 24979

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Pratt

(a) RESIDENCE NO. 818 Shulin St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N-Carolina

(State or country)

PARENTS

10 NAME OF FATHER James Hyfer

11 BIRTHPLACE OF FATHER (City or town) N-C-

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Cox

13 BIRTHPLACE OF MOTHER (city or town) N.C.

(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

Registrar

1927 1612

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927, to Aug-16-, 1927, that I last saw h[illegible] alive on Aug-16-, 1927, and that death occurred, on the date stated above, at 3:45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Peckham, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL, BALTIMORE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 24980

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24980

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3157 Cedar ave ST. 43-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilma L Foster

(a) RESIDENCE NO. 3157 Cedar ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): July 18 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Barbara Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) John Foster

15 Filed 8-23 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/22 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/13/27, 19.. to 8/22, 19 27

that I last saw him alive on 8/22, 19 27

and that death occurred, on the date stated above, at 4 3/4 m.

The CAUSE OF DEATH* was as follows:

acute nephritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) whooping cough.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? typical symptoms

(Signed) C. F. Culbreth, M. D.

(Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Aug 24 1927

20 UNDERTAKER Ellenwood & Son ADDRESS 3678 Chestnut ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 24981

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3207 Guilford Ave. ST.) 12-50 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Coster

(a) RESIDENCE No. 3207 Guilford Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas J. Coster

6 DATE OF BIRTH (month, day, and year): July 18, 1848

7 AGE — Years: 79 — Months: 1 — Days: 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md.

PARENTS

10 NAME OF FATHER: James Fellen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. Benj F. Coster Jr.

(Address) 4700 Old Frederick Rd.

15 Filed Aug 27, 1927 — C. HARRISON JONES, M. D. Registrar

By RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 19, 1927, to Aug 21, 1927,

that I last saw h alive on Aug 21, 1927,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Cairns, M. D.

, 19 (Address) 612 W 40th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middleham Chapel Md. — DATE OF BURIAL: Aug 24, 27

20 UNDERTAKER: Calvert Co — ADDRESS: North St

Mr. Nicholas Sons

Before signing be careful that ALL ITEMS have been answered. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 231327

Spec.—1-12-23—M&T—500 Blks.

Power

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24982 E 24982

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Maryland Ave. St. 12-20 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Prendergast Power

(a) RESIDENCE NO. 2008 Maryland Ave. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 54 yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Preston Pulaski Power

6 DATE OF BIRTH (month, day, and year) April 16, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael P. Caughy

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Prendergast

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Rowena Waylor
(Address) Pikesville

15 Filed 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8, 23 - 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1924, to Aug 23rd, 1927, that I last saw h 22 alive on Aug 22nd, 1927, and that death occurred, on the date stated above, at 2,20 a. m.

The CAUSE OF DEATH* was as follows:

Heart failure, due to Carcinoma of Liver

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Return of Operation 3 mo ago (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1924. St Agnes.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Lockard, M. D.

8, 23 1927 (Address) 211 N. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	8/25, 19 27
20 UNDERTAKER Henry U. Mears & Son	ADDRESS 805 N Calvert

mation should be carefully supplied. Age should be stated EXACTLY. Illegible and incomplete answers cannot be accepted. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Rec—12-23-21—E.B.R.S.—400 Bks.

E 24983

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24983

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

City of BALTIMORE: (No. 423 Scott St. St., 21 Ward)

Registered No. 21729

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Smith

(a) Residence No. 423 Scott St. St., 21 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Smith

6-DATE OF BIRTH (month, day and year) Jan. 9, 1845

7-AGE. 82 yrs. 7 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Brickmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) Mary Smith

(Address) 423 Scott St.

15- Filed AUG 23 1927 192 C. E. AMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 23, 29

17- I HEREBY CERTIFY, That I attended deceased from April 1 1927 to Aug 23 1927 that I last saw him alive on Aug 22 1927 and that death occurred, on the date stated above, at 12.30a.m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(Duration) yrs. 6 mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urin Analysis

(Signed) John G. Silberausberg M.D.

(Address) 1126 W. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. Aug 26 1927

20-UNDERTAKER. Joseph B Cook ADDRESS 1003 N. Gilts St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24984

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 24984

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 707 S. Bouldin St. 24-1 Ward)

2-FULL NAME Christina Ruth

(a) RESIDENCE NO. 707 S. Bouldin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Ruth

6 DATE OF BIRTH (month, day, and year): March 17. 1848

7 AGE: Years 78 Months 5 Days 4 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Germany

PARENTS

10 NAME OF FATHER: John Muller

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Catharine Tuenshen

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant:

(Address): 707 S. Bouldin

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo E. Lawrow M.D.

(Coroner)

19 (Address) 443 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial Aug 24 1927

20 UNDERTAKER: Wendell & Kuppel ADDRESS 360 N. Eden St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24985

CERTIFICATE OF DEATH.

E 24985

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of BALTIMORE: (No. 136 N. Hoffman St. 11-24 Ward)

REGISTERED NO. 75-002

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Hudson.

(a) RESIDENCE NO. 136 N. Hoffman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Hudson

6 DATE OF BIRTH (month, day, and year) ? 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Kitty Hudson

(Address) 136 Hoffman St

15 Filed ..... 19.. ..... Registrar

AUG 23 1927 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis (R. Side)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

Aug 23/27 (Signed) C. C. Coates M. D.

(Coroner)

(Address) 1431 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial 8/24/1927

20 UNDERTAKER Mrs. Geo. E. Holland — ADDRESS 168 Druid Hill ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24986

CERTIFICATE OF DEATH.

90

E 24986

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 N. Chester ST. 6-10 WARD)

2-FULL NAME Annie Glaser

(a) RESIDENCE NO. 15 N. Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., if of foreign birth? 5 yrs. — mos. — ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Simon

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Zorinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rasiel Glaser
(Address) 15 N. Chester St.

15 Filed AUG 24 1927, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1927, to Aug 23, 1927, that I last saw h[er] alive on Aug. 22, 1927 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:
General arterio Sclerosis
Chronic myocarditis
(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) acute Pericarditis
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 2.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R.C. McClellan, M. D.
Aug 23 1927 (Address) 2220 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herring Run Cem't — DATE OF BURIAL 8/24 1927

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1121 E Balto St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24987

CERTIFICATE OF DEATH

72 E 24987

B-5

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. Ward)

BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard A. Sheppard

(a) RESIDENCE NO. None given 1307 E. Baltimore St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE 40 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md

(State or country)

PARENTS

10 NAME OF FATHER Wm H Sheppard

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Caroline Lubecker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Geo H Sheppard

(Address) 133 W. Lafayette Ave.

15 Filed AUG 24 1927 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-7-24 1925, to 8-23 1927, that I last saw him alive on 8-23 1927, and that death occurred, on the date stated above, at 9.00 A. m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? phys. findings

(Signed) C. Holmes Sweet, M. D.

19 Address BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — Date of Burial: Aug 24 1927

20 UNDERTAKER: John Ottenheimer — ADDRESS: Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 24988 — REGISTERED NO. E 24988

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hawkins Catterton

(a) RESIDENCE NO. Owings Md St. Ward Non Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Lee B Catterton

6 DATE OF BIRTH (month, day, and year): Apr 28 1893

7 AGE: Years 34 Months 3 Days 26. IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Mechanicsville
(State or country): Md

PARENTS

10 NAME OF FATHER: Jacobs Hawkins

11 BIRTHPLACE OF FATHER (City or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Morgan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant: Lee B Catterton
(Address): Owings Md

15 Filed AUG 24 1927 C. HAMPSON JONES, M. D. Registrar
By Ralph

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/24 19 27

17 I HEREBY CERTIFY, That I attended deceased from 8/12, 19 27, to 8/24, 19 27, that I last saw her alive on 8/24, 19 ....., and that death occurred, on the date stated above, at 1.10 A m.

The CAUSE OF DEATH* was as follows:

Malignancy in abdomen

(duration) at least 3 mos ds.

CONTRIBUTORY (Secondary): Hemorrhage from bowel

(duration) 1 mos ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? See additional Statement

(Signed) E F Lusby, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendship Cemetery Md Co. Date of Burial: Aug 25 1927

20 UNDERTAKER: D L Hopkins ADDRESS: Annapolis Md

Spec.–7-17-26–A Co.–200 Bks.

Neal Evans.

HEALTH DEPARTMENT—CITY OF BALTIMORE

97-002

E 24989

CERTIFICATE OF DEATH

E 24989

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Neal Evans

(a) RESIDENCE NO. 1005 E Monument St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, (Married) Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 49 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. C.

(State or country)

PARENTS

10 NAME OF FATHER unable to get

11 BIRTHPLACE OF FATHER (City or town)

(State or country) history

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed 1928 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-18 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-18, 1927, to 8-18, 1927.

that I last saw h[redacted] alive on 8-18, 1927.

and that death occurred, on the date stated above, at 8 55 A. m.

The CAUSE OF DEATH* was as follows:

Diagnosis not made Arteriosclerosis

Pt expired immediately on arrival

(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) G Rawson

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of Former Hosp

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Owens Boyd, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

290

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24990

CERTIFICATE OF DEATH.

E 24990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1337 N. Fremont ST. 14-20 WARD)

2-FULL NAME Ornie Wade Sellman

(a) RESIDENCE NO. 1337 N. Fremont ST., 14 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Sellman

6 DATE OF BIRTH (month, day, and year) Dec 25 - 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md

PARENTS

10 NAME OF FATHER John Denmark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Md

12 MAIDEN NAME OF MOTHER Cora Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co. Md

14 Informant Harvey Denmark

(Address) 529 Lansing St

15 Filed AUG 24 1927 19 R M H Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 - 22 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 21, 1927, to Aug 22, 1927, that I last saw h[illegible] alive on Aug 22, 1927 and that death occurred, on the date stated above, at 12.10 A m

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) yrs. mos 2 ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. McKee, M. D

(Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 24 1927
20 UNDERTAKER	ADDRESS
Virginia E. Brooks	1009 E. Cary

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24991

E 24991
REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No.) 1727 Orleans St. 69 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Mood

(a) RESIDENCE NO. 1727 Orleans St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 20. 1927

7 AGE — Years: — Months: 6 — Days: 2 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER Linwood Nash

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Louisa Gross

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Louisa Nash
(Address) 1727 Orleans St

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Intestinal Rickets
(duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) Exhaustion
(duration) ..... yrs. ..... mos. ..... ds.

Aug 23 27 (Signed) G E Yates (Coroner) M. D.
(Address) 143 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill cemetery — Date of Burial: Aug 24 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 24992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓

E 24992

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals 07-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hezekiah Graves

(a) RESIDENCE NO. 219 S. Fremont ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mandy Graves

6 DATE OF BIRTH (month, day, and year) 1871 ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	56 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Alabama

PARENTS

10 NAME OF FATHER Charles Graves

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Alabama

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed AUG 24 1927 19 Baltimore, Md. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 August 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 22, 19 27, to August 21, 19 27,

that I last saw him alive on August 21, 19 27,

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Penis - Primary Testicle

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) S. E. Maddox M. D.

8-21, 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Zion Cem	8/24 19 27
20 UNDERTAKER Edward Brown	ADDRESS 1831 Eutaw St.

Spec.–7-17-26—A Co.—200 Bks.

20 E & C 24993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 24993

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley Smith

(a) RESIDENCE NO. 503 N. Parrish St. Ward City

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5-2-27

7 AGE Years — Months 3 Days 20 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —

(State or country)

PARENTS

10 NAME OF FATHER Walter Smith

11 BIRTHPLACE OF FATHER (City or town) Md —

(State or country)

12 MAIDEN NAME OF MOTHER Inez Carter

13 BIRTHPLACE OF MOTHER (city or town) Md —

(State or country)

14 Informant Parents —

(Address) JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.

15 Filed AUG 24 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927, to Aug 22, 1927, that I last saw h[illegible] alive on Aug 22, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Indigestion

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [signature], M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial Aug. 24 1927

20 UNDERTAKER Samuel Stansbury ADDRESS 578 N. Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24994

CERTIFICATE OF DEATH.

129 E 24994

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 633 N. Paca St, 17-25 Ward)

2-FULL NAME Daniel D. Johnson

(a) RESIDENCE NO. 633 N. Paca St, St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 1/4 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillian Johnson

6 DATE OF BIRTH (month, day, and year): About May, 1875

7 AGE: Years: About 52 Months: Days: IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: Lewis Johnson

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Cooper

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Md

14 Informant: Lillian Johnson
(Address): 633 N Paca St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 22, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. T. Hennessy, M. D.
(Coroner)

19 27 (Address) 702 Equitable

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem. Date of Burial: Aug. 25th 19 27

20 UNDERTAKER: Samuel Hemsley ADDRESS: Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 24995 ✓ E 24995

CERTIFICATE OF DEATH

49

1-PLACE OF DEATH Lake Drive near Linden Ave.

REGISTERED NO. 13-59

City of BALTIMORE: (No. Alhambra Apts. 1 E. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isidore Rich

(a) RESIDENCE NO. Alhambra Apts. 1 E. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Rich

6 DATE OF BIRTH (month, day, and year) Jany. 11, 1877.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired manufacturer of

(b) General nature of industry, business, or establishment in which employed (or employer) reed furniture.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Md.

PARENTS

10 NAME OF FATHER Myer Rich

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Greentree

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Hattie Rich

(Address) Alhambra Apts.

15 Filed ; 19 Registrar

AUG 24 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 19 27

17 I HEREBY CERTIFY, That I attended deceased from March, 19 26, to August 22, 19 27,

that I last saw him alive on August 22, 19 27,

and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

(a) Brain Tumor

Left Cerebral Hemisphere

(Glioma) inoperable

(duration) 1 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted no —

if not at place of death?

Did an operation precede death? Date of March 8/26

Was there an autopsy? no

What test confirmed diagnosis? + Ray + operation.

(Signed) Louis E Grimm, M. D.

, 19 (Address) 722 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Hebrew Cem.	8/24/ 19 27

20 UNDERTAKER David Sondheim ADDRESS 118-20 W. Mt. Royal Ave.

operated on by Dr. Dandy at Johns Hop Hosp.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 24996 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 1

E 24996

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3814 Fernwood ave ST. 26-31 WARD)

2-FULL NAME William Brendel

(a) RESIDENCE NO. 3814 Fernwood ave ST. ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frances Brendel

6 DATE OF BIRTH (month, day, and year) May 9- 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Brendel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont know

14 Informant Frances Brendel
(Address) 3814 Fernwood ave

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/1/27, 19....., to 8/22, 1927.

that I last saw h (alive on 8/17/27, 19.....

and that death occurred, on the date stated above, at 3.55 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. E. Garrell, M. D.

8/22, 1927 (Address) 633-5-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	aug 25 1927
20 UNDERTAKER George W. Zirkle	ADDRESS 1737 E. Eager

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49

E 24997

CERTIFICATE OF DEATH

E 24997

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. ____ St. 27-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William M. Hayden

(a) RESIDENCE NO. 210 Roland Ave St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: May Burkhurst

6 DATE OF BIRTH (month, day, and year): March 24th 1848

7 AGE: Years 79 Months 4 Days 29 IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Banker

(b) General nature of Industry, business, or establishment in which employed (or employer): President of

(c) Name of employer: Eutaw Savings Bank

9 BIRTHPLACE (city or town): Elkcott City

(State or country)

PARENTS

10 NAME OF FATHER: Edward D. Hayden

11 BIRTHPLACE OF FATHER (City or town): Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Hause

13 BIRTHPLACE OF MOTHER (city or town): Philadelphia Pa

(State or country)

14 Informant: Mr. Wm. M. Hayden

(Address): Hosp Road

15 Filed AUG 24 1927, 19 ____ C. HERBERT JONES, M. D. Registrar

Per R. H. C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-23-27

17 I HEREBY CERTIFY, That I attended deceased from 8-21-27, 19____, to 8-23-27, 19____,

that I last saw him alive on 8-23-27, 19____,

and that death occurred, on the date stated above, at 12:42 A. M.

The CAUSE OF DEATH* was as follows:

Malignancy of urinary tract

Carcinoma of Prostate & Metastasis

(duration) 1 yrs. ____ mos. ____ da.

CONTRIBUTORY (Secondary) Hardening of Bronchial Lymph

(duration) ____ yrs. ____ mos. 5 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 8-22-27

Was there an autopsy? No

What test confirmed diagnosis? Unconfirmed

(Signed) R. G. Hazard, M. D.

8-23-1927 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem

Date of Burial 19

20 UNDERTAKER: Kemp & Jenkins Sons

ADDRESS: McCulloh & Eutaw Sts.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 24998 HEALTH DEPARTMENT—CITY OF BALTIMORE E 24998

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 N Decker av ST., 6 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Bauer

(a) RESIDENCE NO. 618 Decker av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frances Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Erwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant Jno Canfield

(Address) 618 Decker av

15

Filed AUG 29 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/22 1927.

17

I HEREBY CERTIFY, That I attended deceased from 8-16, 19 27, to 8-22, 19 27,

that I last saw her alive on 8-22, 19 27,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chr Pulmonal

MYOCARDITIS

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asc. Pul. Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Jones M. D.

8/23 19 27 (Address) 1939 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Aug 25 1927

20 UNDERTAKER John A Fields ADDRESS 1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 24999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 24999

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 W. Lombard St., 16 Ward)

2-FULL NAME John E. Willis

(a) RESIDENCE NO. 1104 W. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): July 1st 1927

7 AGE: Years — Months 1 Days 23 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Wm E. Willis

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Alice Ledley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Alice Willis

(Address) 1104 W. Lombard St

15 Filed ..... 19..... Registrar

AUG 24 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 23rd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest or inquiry) thereon and from the evidence obtained (Inquest or inquiry) and that said deceased came to (Inquest or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough 3 WEEKS

(duration) ..... yrs.

CONTRIBUTORY (Secondary)

(Signed) Thos. B. Norton M. D.

Aug 25 1927 (Coroner) (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See Instructions for Certificate.) Bacteria

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Date of Burial Aug 24 1927

20 UNDERTAKER: John J. Fuldo ADDRESS 1200 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25000
1-PLACE OF DEATH

90 E 25000
REGISTERED NO.

City of BALTIMORE: (No. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bailey

(a) RESIDENCE NO. Gaulsbury Alley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE 73 Years Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Chas. A-

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant Boarding House (Address)

15 Filed AUG 24 1927 19 Registrar RMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-20, 1927, to 8-23, 1927, that I last saw him alive on 8-23, 1927, and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chr.
Arteriosclerotic heart disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertention

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. findings

(Signed) C. Holmes Boyd, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial: Aug 24 1927

20 UNDERTAKER: Daniel Easton ADDRESS 916 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 blks.

E 25001

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25001

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2402 E. Oliver ST. 8-16 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lide L. Zerner

(a) RESIDENCE No. 2402 E. Oliver ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rudolph G. Zerner

6 DATE OF BIRTH (month, day, and year): 9 | 28 | 1882

7 AGE — Years: 44 — Months: 11 — Days: 25 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Bagwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary A. Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Rudolph G. Zerner

(Address): 2402 E. Oliver Street

15 Filed AUG 24 1927 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-22-1927

17

I HEREBY CERTIFY, That I attended deceased from 7-15, 19 27 to 8-22, 19 27

that I last saw h alive on 8-21, 19 27

and that death occurred, on the date stated above, at 9 A m

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic with Acute Infection Superimposed

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Fred Zeigler M. D.

8-23-27 (Address) 2000 N. Ann St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: 8/25 1927

20 UNDERTAKER: George & Ruth

ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E.25002 HEALTH DEPARTMENT—CITY OF BALTIMORE E.25002

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2100 E Baltimore St. 15-58 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Fine

(a) RESIDENCE NO 2920 Violet ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Fine

6 DATE OF BIRTH (month, day, and year): — 1833

7 AGE — Years: 94 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Pincus Fine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Putkam

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Ida Fine
(Address): 2920 Violet ave

15 Filed ..... 19 ..... C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/23 1927

17

I HEREBY CERTIFY, That I attended deceased from June, 1927, to Aug 22, 1927, that I last saw h alive on Aug 22, 1927 and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

~~ortic~~

Myocardial degeneration

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) arterio sclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address) 1515 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Lauthan Cem

DATE OF BURIAL: 8/24 19 27

20 UNDERTAKER: Jack Lewis 1439 E Balt St

ADDRESS

8 24 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25003

E 25003

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Supposedly on Patapsco St

City of BALTIMORE, No. Near Fairfield Ave (Ward) Between Curtis Bay Broadway & Albert Johnston 11-24

2-FULL NAME

(a) RESIDENCE NO. 360 Oxford St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colrd

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: about 45 Years — Months — Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Unknown

(State or country): Unknown

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

PARENTS

14 Informant: Southern Police Sta

(Address) City

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Head injuries stated supposedly by Street Car — Striking Same

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Aug 23rd 1927 (Signed) Thos. B. Hutton M. D. (Coroner)

(Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY

Date of Burial: 19

20 UNDERTAKER: C. HAMILTON JONES, M. D.

ADDRESS

380 1927 Reg ARC

MARGIN RESERVED FOR BINDING

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. ATE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Blks.

E 25004

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25004

CERTIFICATE OF DEATH

161-001

1-PLACE OF DEATH Union Memorial Hosp — REGISTERED NO.

City of BALTIMORE: (No. 33d & Calvert Sts. St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Agnes Bennett

(a) RESIDENCE NO. 1063 Denver St. Ward Balto. Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 20 1927

7 AGE — Years: 0 — Months: 3 — Days: 4 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER J. E. Bennett

11 BIRTHPLACE OF FATHER (City or town): Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Hartman

13 BIRTHPLACE OF MOTHER (city or town): Howard Co., Md
(State or country)

14 Informant: Father
(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Aug 24, 1927, that I last saw her alive on Aug 23, 1927, and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows:

Pemphigus Gangrenosa

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Toxemia Pregnancy

(duration) yrs. 3 mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Hist

(Signed) Wallace R. Swartzwelder M. D.

. 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — Date of Burial: Aug 26 1927

20 UNDERTAKER: Woy Cook — ADDRESS: 504 E. Mad

AP 22

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Un 1845

Record 320 St Paul

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25005

CERTIFICATE OF DEATH.

E 25005

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3513 Gough ST., N-W WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J Ricker

(a) RESIDENCE No. 3513 Gough ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced (or) ~~WIFE~~ of Margaret Ricker

6 DATE OF BIRTH (month, day, and year) Unknown 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Emily Ricker

(Address) 3513 Gough St

15 Filed AUG 24 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927, to Aug 23, 1927, that I last saw h~~im~~ alive on Aug 22 1927 and that death occurred, on the date stated above, at 12 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) One yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Rupard M. D.

(Address) 320 St Paul

8/23 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Aug 26 1927
20 UNDERTAKER William Cook	ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Geyers
1031 N. Caroline

E 25006

CERTIFICATE OF DEATH.

45 E 25006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 North Wolfe ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Kaufman

(a) RESIDENCE NO. 1811 N. Wolfe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
or) ~~WIFE~~ of Augusta Kaufman

6 DATE OF BIRTH (month, day, and year) Feb 22-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cattle Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Augusta Kaufman
(Address) 1811 N. Wolfe St

15 Filed ....., 19..... Registrar

AUG 24 1927 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1927, to Aug. 23rd, 1927
that I last saw h[illegible] alive on Aug. 22nd, 1927
and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 10/1/26.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harold A. Meyer M. D.

8/24, 1927 (Address) 1037 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Aug 26 1927

20 UNDERTAKER Wm Cook

ADDRESS 512 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25007

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3239 Clifton Ave (ST.) 15-67 (WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Loretta S. Reagan

(a) RESIDENCE NO. 3239 Clifton Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Franklin Reagan

6 DATE OF BIRTH (month, day, and year): Apr 16 1847.

7 AGE: Years 80; Months 4; Days 8; If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wayne Co., Pennsylvania

PARENTS

10 NAME OF FATHER: Dyer J. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wayne New York

12 MAIDEN NAME OF MOTHER: Nancy S. Wier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mercer Co. Pennsylvania

14 Informant: Lt. Col. Alan Lawrence Reagan

(Address): Albany N. Y.

15 Filed ..., 19 ... Registrar ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to Aug 24, 1927, that I last saw her alive on Aug 24, 1927 and that death occurred, on the date stated above, at 7.05 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic cardiovascular disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Coronary Thrombosis.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) W. M. Foster, M. D.

, 19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Albany, N.Y.

DATE OF BURIAL: 8/25 1927

20 UNDERTAKER: J. Pickett Sons

ADDRESS: Ca No Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING: REGISTERED FOR BINDING

G 4 1927 C. HAMPTON JONES, M.D.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 25008 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25008

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1707 Carlisle Ave 8-17-27 REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Goldsborough (GOLDSBEERY)

(a) RESIDENCE NO. 1707 Carlisle Ave ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Goldsborough

6 DATE OF BIRTH (month, day, and year) June 1 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brunswick Co Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Armanda Hums

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Goldsborough (Address) 1707 Carlisle Ave

15 Filed AUG 24 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-22 1927

17

I HEREBY CERTIFY, That I attended deceased from 8-17- , 1927 , to 8-22 , 1927 ,

that I last saw h[illegible] alive on 8-20 , 1927 ,

and that death occurred, on the date stated above, at 2 00 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis (acute)
Acute Nephritis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. T. B. Butler , M. D.

, 19 (Address) 725 N. Carlisle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Brunswick Co Va	Aug. 28, 27
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1725 Ashland Ave

Spec.—1-12-23—M&T—500 Blks.

E 25009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25009

1-PLACE OF DEATH Bon Secours Hospt

CITY OF BALTIMORE: (No. 339 S Stricker St. 1928 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Gerber

(a) RESIDENCE No. 339 S Stricker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 11 1863

7 AGE Years 64 Months 7 Days 11 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conduit Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John C Gerber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Ann Crotty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Margaret Crotty

(Address) 339 S Stricker

15 Filed AUG 24 1927, 19 Pat ACR Registrar

C. HAMSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to Aug 22, 1927, that I last saw him alive on Aug 22, 1927, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Post Mortem

(Signed) George O. Eaton, M. D.

, 19 (Address) Bon Secours Hosp'l.

*State the Disease Causing Death, & in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 8/25 19 27

20 UNDERTAKER George A Tarby

ADDRESS Fallsway & Oliver

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25010

CERTIFICATE OF DEATH

E 25010

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1118 Ridgely St., 21-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Leonard.

(a) RESIDENCE NO. 1118 Ridgely St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen P Leonard.

6 DATE OF BIRTH (month, day, and year): July 1st 1852

7 AGE: Years 75 Months 1 Days 21

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): City Fire Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia.

PARENTS

10 NAME OF FATHER: Wm Leonard

11 BIRTHPLACE OF FATHER (City or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Mrs Catherine Weaver

(Address) 1118 Ridgely St

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

Per R.R.S.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-22 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-18 1927 to 8-22 1927 that I last saw h[illegible] alive on 8-22 1927 and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Raphael Dunn M. D.

8, 19 (Address) Mary Mount Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial 8-25 1927

20 UNDERTAKER: Bernard C Harle ADDRESS 1000 L Paca St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 4 1927

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25011 E 25011

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Norman Avenue ST.) 40 W 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John William Joynes

(a) RESIDENCE NO. 515 Norman Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Parker

6 DATE OF BIRTH (month, day, and year) Oct 7th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	10.	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Accomac County (State or country) Virginia

PARENTS

10 NAME OF FATHER Edward D. Joynes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Margaret Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Roland H. Joynes (Address) Homewood Apartments

15 Filed AUG 24 1927, 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23. 1927

17 I HEREBY CERTIFY, That I attended deceased from for many years, to date of death, that I last saw h[illegible] alive on Aug. 23, 1927, and that death occurred, on the date stated above, at 11.20 A, m.

The CAUSE OF DEATH* was as follows:

Death was due to a long standing Interstitial Nephritis

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilitation

Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Lee Davis, M. D.

, 19 (Address) 82 W. Hamilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 8/25, 19 27

20 UNDERTAKER Henry W. Peters & Son — ADDRESS 805 N Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25012

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25012

CERTIFICATE OF DEATH.

X 10-092

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., (WARD) 9-45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peta Tussarella

(a) RESIDENCE NO. Benges ST., Maryland WARD

(Usual place of abode)

Length of residence in city or town where death occurred [redacted] yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jim Tussarella

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Amelia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Jim Tussarella (Address) Benges Md.

15 Filed AUG 24 1927 C. HAMILTON JONES, M. D. Registrar

Per RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1927, to Aug 23, 1927, that I last saw h[illegible] alive on Aug 23, 1927 and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Pharyngeal & Laryngeal Diphtheria (duration) from History yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No (Date of Intubated 8/23/27)

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Pos. Cult.

(Signed) Myron G. Tull M. D.

8/24, 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Aug 25 1927

20 UNDERTAKER Waddell & Hippel ADDRESS 300 S Eden St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25013

E 25013

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1347 W Lafayette Ave ST. WARD)

2-FULL NAME Mary K. Crowner

(a) RESIDENCE NO. 1347 W. Lafayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Kate Jones 1347 W Lafayette Ave

15 Filed AUG 25 1927 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1927, to Aug 21, 1927, that I last saw h alive on Aug 21, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Joseph Linder, M. D.

, 19 (Address) 2348 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Aug 25 27

20 UNDERTAKER: Thos. M. Johnson

ADDRESS 1234 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25014

CERTIFICATE OF DEATH.

E 25014

1-PLACE OF DEATH

City of BALTIMORE: (No. Notre Dame College St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Philippine Mannebeim

(a) Residence No. Notre Dame College St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of not married

6-DATE OF BIRTH (month, day and year) Nov 25 1850

7-AGE, 77 yrs. 4 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sister of Notre Dame

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Fort Madison (State or Country), Iowa

PARENTS.

10-NAME OF FATHER, John Mannebeim

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine Dirker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Rev M Agatha

(Address) Notre Dame College

15- Filed AUG 25 1927 19 R.M.A.C. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 24 1927

I HEREBY CERTIFY, That I attended deceased from Jan 10 19 27 to Aug 24 19 27

that I last saw h alive on Aug 22 19 27

and that death occurred, on the date stated above, at 12.20 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast (Left)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion & Toxemia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Lowe M. D.

Aug 24 19 27 Address 7 Washington Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Govanstown Private Cem. DATE OF BURIAL, Aug 26 19 27

20-UNDERTAKER, Frank A. Kirk ADDRESS 915 N. Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25015

CERTIFICATE OF DEATH

57 E 25015

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

1-PLACE OF DEATH

City of BALTIMORE: (No. 2505 E Federal St., 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Faulhaber

(a) RESIDENCE NO. 2505 E Federal St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 3 mos. ds. How long in U. S. if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Faulhaber Sr.

6 DATE OF BIRTH (month, day, and year): May 23 1853

7 AGE — Years: 74 Months: 3 Days: — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto (State or country): Md

PARENTS

10 NAME OF FATHER: John Pfaffenbach

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Herrman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Andrew Faulhaber Sr.

(Address) 2505 E Federal St

15 Filed AUG 25 1927 19 C. Humphreys Jones M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 23 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/12 1926 to 8/23 1927.

that I last saw h alive on 8/23 1927.

and that death occurred, on the date stated above, at 11 25 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) 3 yrs. ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller M. D.

8/23 1927 (Address) 1500 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Aug. 26 1927

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1501 E Eager St

Cor.—12-9-25—A Co.—200 Bks.

Letter w' file from Dr Reinhardt Coroner Dated aug 29/1927

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25016

CERTIFICATE OF DEATH.

90

E 25016

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 16 Cherry St. Curtis Bay. St. 25-77 Ward)

2-FULL NAME Teofil Szymborski.

(a) RESIDENCE NO. 16 Cherry St. Curtis Bay. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) xxxxxxxxxxxx xxxxxxxx Louise Szymborski.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	70 ~~78~~	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Black smith.

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Poland.

PARENTS

10 NAME OF FATHER Matthias Szymborski.

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Poland.

14 Informant Louise Szymborski. (wife)

(Address) 16 Cherry St. Curtis Bay.

15 Filed AUG 25 1927 19____ C. HUNSON JONES, M. D. Registrar

RBG

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) August 24, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) [signature] M. D.

(Coroner)

8/25 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL D. Johns Cross Keys Date of Burial Aug 27 1927

20 UNDERTAKER F. W. Ozarowski ADDRESS 930 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

E 25017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 25017

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 247 O'Reed Ave St. 27-56 90 WARD)

2-FULL NAME John Voly

(Residence in Baltimore: No. 247 O'Reed Ave St.; ....yrs. ....mos. ....ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, July 7 (Month) (Day), 1844 (Year)

7-AGE, 83 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Voly

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Yost.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christian Voly

(Address) Pikesville Md.

15-

Filed ....., 191.... C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 24 (Month) (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 28 1927, to Aug 23 1927, that I saw h[illegible] alive on Aug 23 1927, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ....yrs. ....mos. ....ds.

(Signed) E E Nichols M. D.

8/24, 1927 (Address) Pikesville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Forest Park Cemetery — DATE OF BURIAL, Aug 26, 1927

20-UNDERTAKER Frank H. Newell — ADDRESS Pikesville Md

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH PEN AND INK—THIS IS A PERMANENT RECORD

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25018 — REGISTERED NO. E 25018

179

1-PLACE OF DEATH

City of BALTIMORE: (No. J. H. Hospital St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sidney Sober

(a) RESIDENCE NO. 1825 E Fairmount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 9 mos. ds. How long in U. S., if of foreign birth? 4 yrs. 9 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1922

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nor l

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Nathan Sober

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Jessie Solman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Nathan Sober

(Address) 1825 E Fairmount Ave

15 Filed ..... 19 ..... Registrar

AUG 25 1927 HARRY JONES, M. D.

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture Multiplex Acc Burns 2nd & 3rd Degree

(Duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 1 ds.

(Signed) C. E. Stokes M. D.

(Coroner)

Aug 25 1927 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Cl Date of Burial 8/25 1927

20 UNDERTAKER A. J. Levinson ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25019

CERTIFICATE OF DEATH

28

E 25019

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amos McCauley.

(a) RESIDENCE NO. 3445 Fall Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mollie McCauley

6 DATE OF BIRTH (month, day, and year): July 22 1860

7 AGE: Years 67 Months 1 Days 2

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired railroad

(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Richard Mat Known

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Baked Not Known

12 MAIDEN NAME OF MOTHER: Richard Mat Known

13 BIRTHPLACE OF MOTHER (City or town)

(State or country): Baked Not Known

14 Informant: Mrs Blanche Walker

(Address) 3445 Fall Road

15 Filed ..... 19 ..... Registrar

AUG 25 1927 G. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/24 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/23, 1927, to 8/24, 1927

that I last saw h[illegible] alive on 8/24, 1927

and that death occurred, on the date stated above, at 11 50 m.

The CAUSE OF DEATH* was as follows:

Hydrophobia (Rabies)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? University Hosp.

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) F. G. Lasby, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cem. Date of Burial (May 2) 192[illegible]

20 UNDERTAKER: A. S. Marshall ADDRESS 3539 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 25020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25020

112

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 823 Cloney st. ST. 18-16 WARD)

2-FULL NAME John Hays

(a) RESIDENCE. No. 823 Cloney St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855 - Aug 15

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John Hays

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Anne Courtney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Jones
(Address) 823 Cloney St.

15 Filed ... 19 ...
Registrar
Per

AUG 25 1927 C. HAMPSON JR. M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1927, to Aug 24, 1927, that I last saw him alive on Aug 23, 1927, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis
(duration) yrs. 4 mos. 19 ds.

CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J Murray, M. D.

, 19 (Address) 516 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 26 19 27

20 UNDERTAKER John J Fields ADDRESS 1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25021

CERTIFICATE OF DEATH.

75-001

E 25021 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1623 S. Charles ST. 2334 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Wholahan Aloysius McLane

(a) RESIDENCE. No. 1623 S. Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Fannie Graves McLane

6 DATE OF BIRTH (month, day, and year): 31 July 1859

7 AGE: Years 68 Months 0 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Asst Supt Fuel Gas Dept

(b) General nature of industry, business, or establishment in which employed (or employer): Municipal Gas

(c) Name of employer: Consolidated Gas Co

9 BIRTHPLACE (city or town) (State or country): Washington D. C.

PARENTS

10 NAME OF FATHER: John McLane

11 BIRTHPLACE OF FATHER (city or town) Kildare, (State or country) County Clare - Ireland

12 MAIDEN NAME OF MOTHER: Honora Creham

13 BIRTHPLACE OF MOTHER (city or town) Kildare, (State or country) County Clare - Ireland

14 Informant: Fannie Graves McLane (Address) 1623 South Charles St.

15 Filed AUG 25 1927, 19 C. Hamilton Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from 20 Aug. 1927. to 24 Aug. 1927. that I last saw h[illegible] alive on 23 Aug. 1927. and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary): Hemiplegia - Right

(duration) 1 yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic

(Signed) Edward McSweeney M. D.

, 192 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: 8/27 27

20 UNDERTAKER: Margaret J. Flynn ADDRESS: 1411 Eutaw St.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 E 25022

REGISTERED NO. E 25022

1-PLACE OF DEATH

City of BALTIMORE: (No. 2607 Maryland Ave. St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank G. Dawson

(a) RESIDENCE NO. 2607 Maryland Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
(or) WIFE of Mrs. Dawson

6 DATE OF BIRTH (month, day, and year)
Aug. 6th. 1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43		18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) North Carolina

PARENTS

10 NAME OF FATHER Benjamin F. Dawson
11 BIRTHPLACE OF FATHER (City or town)
(State or country) North Carolina
12 MAIDEN NAME OF MOTHER Mary Mehegan
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Mrs. Dawson
(Address) 2607 Maryland Ave.

15 Filed AUG 25 1927 19 C. HARRISON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 24 19 27.

17 I HEREBY CERTIFY, That I attended deceased from July 1926, to Aug 24 1927.
that I last saw h. alive on Aug 24 1927.
and that death occurred, on the date stated above, at 8.40 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
(duration) — yrs. mos. ds.
CONTRIBUTORY (Secondary) Carcinoma of upper palate.
(duration) about 5 years. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Microscopic Exam. by Dr. Schwentker
(Signed) John H. Schwentker, M. D.
. 19 (Address) 1337 E Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Rocky Mount N.C.	8/25/27 19

20 UNDERTAKER Chas. F. Cranston ADDRESS 1180 N. Howard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25023
1-PLACE OF DEATH

REGISTERED No. E 25023

City of BALTIMORE: (No. 1729 W. Lanvale St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva T. Haley

(a) RESIDENCE NO. 1729 W. Lanvale St. Ward Inquest

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 22, 1926

7 AGE: Years 1 Months Days 2 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Faquier Va

PARENTS

10 NAME OF FATHER Herbert Haley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Faquier Va.

12 MAIDEN NAME OF MOTHER Geneva Hart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Faquier Va

14 Informant Geneva Hart

(Address) 1729 W. Lanvale st

15 Filed AUG 25 1927 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inq (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sepsis Colitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) has other history of contagious or infectious disease

(duration) yrs. mos. ds.

(Signed) D. F. Hennessy M. D.

(Coroner)

Aug 24th 1927 (Address) 2597 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Beaton Va Date of Burial Aug 27 D27

20 UNDERTAKER Mrs. K. C. Elliott ADDRESS Midland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26–A Co.–200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25024

CERTIFICATE OF DEATH

101-001

E 25024

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Reynolds

(a) RESIDENCE NO. 138 Calvin St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White Black.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1871

7 AGE Years 57 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Jane Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisiana

14 Informant Rebecca Reynolds

(Address) 1732 E. Fayette St

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Aug. 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1927, to Aug. 23, 1927

that I last saw him alive on Aug. 23, 1927.

and that death occurred, on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & Generalized Arteriosclerosis,

Lobar Pneumonia (2 days duration)

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. Bleyer M. D.

19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery — Date of Burial: Aug 26 1927

20 UNDERTAKER: Wm. H. G. Elbert — ADDRESS: 1525 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 29 CHARLTON JONES, M. D.

Cor.—12-9-25—A Co—200 Bks.

E 25025

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25025

CERTIFICATE OF DEATH.

REGISTERED NO. 194

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospital St. Ward)

2-FULL NAME Giovanni Vallorani

(a) RESIDENCE NO. 321 E. Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Enrica Vallorani

6 DATE OF BIRTH (month, day, and year) 2/13/1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem

(c) Name of employer Ship yards

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Emile Vallorani

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Domenica

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Enrica Vallorani

(Address) 321 E Pratt St

15 Filed ..... 19 ..... Registrar

C. HARRISON JONES, M. D.

AUG 25 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatal Prostration

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Heat stroke

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. T. Hennessy M. D.

(Coroner)

Aug 24, 1927 (Address) 2807 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 321 E Pratt St

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

Date of Burial Aug 27, 27

20 UNDERTAKER John Ullrich

ADDRESS 2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Phones
Wolfe 1123 or 6070

JOHN ULLRICH
FUNERAL DIRECTOR

2006-2008 ORLEANS ST.

BALTIMORE, MD. December 7th 1933

Dr Huntington Williams
Balto City Health Dept.
Baltimore Md.

Dear Dr Huntington. The name given of my Husband who died at Md Gen Hospital should be Giovanni Vallorani. and my name Should be

Enrica Vallorani.

State of Maryland
City of Baltimore

Personally appeared before me a Notary Public this 7th. day of December 1933 Enrica Vallorani and made oath in due form of the Law, that the above statement is true.

Enrica Vallorani.
Marguerite Herzog
Notary Public

approved for change.
Huntington Williams M.D.
Coroner who signed certificate is dead.
Hospital records searched

Correction
Made 12/8/33
H. C. Moore
Chief Clerk

May 22-1934.

This is to certify that the parent of Giovanni Vallorani, who was registered dead in the Health Department of the City of Baltimore, under register #E 25025, proper name is Emidio Vallorani instead of that of Emile Vallorani which is an error in the original death certificate.

Witness:
Joseph L. Valentine

Enrica Vallorani

State of Maryland

City of Baltimore

Subscribed and sworn to this 23d day of May 1934

Isaac Berman
Notary Public

Spec.-7-17-26—A Co.—200 Bks.

Gillen

E 25026

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 72 E 25026

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals (Balto.) St. 26-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Gillen

(a) RESIDENCE NO. 121 N. East ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year)
1864

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 463

(b) General nature of industry, business, or establishment in which employed (or employer) Police Department

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John B. Gillen

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Zang

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed AUG 25 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
August 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 16, 19 27, to August 24, 19 27, that I last saw him alive on August 24, 19 27, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY Tuberculosis of Lung
(Secondary)

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

8-24-19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial 8/27 19

20 UNDERTAKER Mc Guire & Carroll Inc. ADDRESS 4205 Fairfield Ave.

Spec.—1-12-23—M&T—500 Blks.

Potts

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25027

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

HAVE 25027

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 608 E. 20th. ST., 9-46 WARD)

2-FULL NAME John W. Potts

(a) RESIDENCE NO. 608 E. 20th. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Green

6 DATE OF BIRTH (month, day, and year) July 22, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) of City Fire Department.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William J. Potts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Petersburg Va.

14 Informant Henry B. Potts (Address) 111 Wolfe Street

15 Filed AUG 25 1927, 19 R. H. Douglass, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 20th, 1927, to Aug 23d, 1927, that I last saw h[illegible] alive on Aug. 23d, 1927, and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Urinary Bladder (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Monninger M. D.

8-23, 1927 (Address) 823 E Nolte Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 8/27, 19

20 UNDERTAKER Henry W. Dears & Son

ADDRESS 845 N. Calvert

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65-002

E 25028

1-PLACE OF DEATH E 25028

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 702 Lennox St. (St.,) 13-59 (Ward)

2-FULL NAME Sarah Merryman Wiede

(a) RESIDENCE NO. 702 Lennox St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ~~Edwin~~ Charles S. Wiede

6 DATE OF BIRTH (month, day, and year) Dec 4, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nelson Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Lennox
(Address) 702 Lennox St

15 Filed AUG 29 1927, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1927, to Aug 24, 1927, that I last saw h alive on Aug 24, 1927 and that death occurred, on the date stated above, at 11.15 P.m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical findings

8/24 1927 (Signed) Wm Howard Jr M. D.
(Address) 170 2 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DRUID RIDGE CEMETERY — DATE OF BURIAL 8/27 1927

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 W. Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25029 E 25029

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 307 Collins Ave ST., 70-71 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Janie E Robinson

(a) RESIDENCE NO. 307 Collins ST., W WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Widow~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Robinson Dec

6 DATE OF BIRTH (month, day, and year): May 9-1850

7 AGE: Years 77 Months 3 Days 6 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Isaac Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Leroy Robinson

(Address) 307 Collins

15 Filed AUG 25 1927, 19 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 25 1927

17

I HEREBY CERTIFY, That I attended deceased from August 1, 1926, to August 25, 1927, that I last saw her alive on August 24, 1927, and that death occurred, on the date stated above, at 4.40 a m.

The CAUSE OF DEATH* was as follows:

Senile Decay

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Henry J Stahn, M. D.

Aug 25, 1927 (Address) 2 E. N Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Central M. E. Church Cemetery - Barstow, Calvert Co. Md.

DATE OF BURIAL: Aug. 27 1927

20 UNDERTAKER: Charles J. Schwab

ADDRESS 505 N. Monroe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25030

CERTIFICATE OF DEATH.

90 E 25030

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

2-FULL NAME Catherine Hearn

(a) RESIDENCE NO. Preston & Valley St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. ____ mos. ____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 27th 1847

7 AGE: Years 79 (80) Months 9 Days 27 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Ireland

PARENTS

10 NAME OF FATHER John Hearn

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Casey

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland

14 Informant (Address) Little Sisters of the Poor Preston & Valley

15 Filed _____, 19____ C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Aug 24th

17 I HEREBY CERTIFY, That I attended deceased from No record, 19____, to _____, 19____, that I last saw h__ alive on 22, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

unknown (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) General dropsy

(duration) ____ yrs. ____ mos. ____ ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Wame, M. D.

Aug 25, 1927 (Address) 1133 E Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Date of Burial: Aug 26 1927

20 UNDERTAKER: Bela Weedefeld ADDRESS: 9 E Franklin St

NOTICE PLEASE!—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 25031 (263)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25031 (38)

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. JOHNS HOPKINS HOSPT St. 6-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bay Jacks

(a) RESIDENCE NO. 718 N. Bethel St. Ward City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16, 1927

7 AGE — Years: — Months: 1 — Days: 5 — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Wilbur Jacks

11 BIRTHPLACE OF FATHER (City or town) N. C. —
(State or country)

12 MAIDEN NAME OF MOTHER Mary Parker

13 BIRTHPLACE OF MOTHER (city or town) N. C. —
(State or country)

14 Informant Reads
(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 25 1927, 19 — 4614 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 30, 19 27, to Aug 21, 19 27, that I last saw h[illegible] alive on Aug 21, 19 27, and that death occurred, on the date stated above, at 11:25 P. M.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis - Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute G.I. Infection, Pneumonia

(duration) yrs. mos. 5 Days 1 Days ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. E. Rothermund, M. D.

19 (Address) Path. Dept. Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

HARRISON JONES, M. D.
JOHNS HOPKINS HOSPITAL AUG 25 1927
Commissioner of Health

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25032

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 E 25032

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary 10-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby. Malcolm.

(a) RESIDENCE NO. Magnolia Md. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 40 wks hours (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 8-22-27

7 AGE	Years	Months	Days	If LESS than 1 day old
				4 hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Church Home & Infirmary

PARENTS

10 NAME OF FATHER Archer Malcolm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Beulah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Dr. Mrs. Grainger Tolltedale (Address) Church Home & Infirmary

15 Filed ..... 19 .....

1640 A K B Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 / 1927

17

I HEREBY CERTIFY, That I attended deceased from 8-22. 1927. to 8-24. 1927.

that I last saw h[illegible] alive on 8-24 . 1927.

and that death occurred, on the date stated above, at 12 30 noon.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) from birth mos. ds.

CONTRIBUTORY (Secondary) Atelectasis (duration) from birth mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) M Grainger Tolltedale M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

295

AUG 1927 JOHNS HOPKINS HOSPITAL

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25033

CERTIFICATE OF DEATH.

90 E 25033

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mw Md. St., 8-16 Ward)

2-FULL NAME Frank F. Nierhaus

(a) RESIDENCE NO. 1300 N Rose St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Albers

6 DATE OF BIRTH (month, day, and year): 8/1/1879

7 AGE — Years: 48 — Months: 0 — Days: 22 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Germany

PARENTS

10 NAME OF FATHER: John Nierhaus

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Francis Nierhaus

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Herman Nierhaus

(Address): 1300 N Rose St

15 Filed.....19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 24 1927

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Chronic (Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

Acute (Duration) yrs. mos. 1 ds.

Aug 25/27 (Signed) C. Chanson Jones M. D.

(Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: 8/26 1927

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Hanford Ave

N. B.—WRITE PLAINLY, WITH INK. ALL BLANKS MUST BE FILLED. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C CHANSON JONES M D

AUG 25 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25034

CERTIFICATE OF DEATH.

× 86-001

E 25034

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 25-12 Ward)

2-FULL NAME James Sander

(a) RESIDENCE NO. Emmitsburg Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary

(c) Name of employer Mr. Hope Retreat

9 BIRTHPLACE (city or town)

(State or country) Emmitsburg Md

PARENTS

10 NAME OF FATHER George Sander

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Malinda Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant M. F. Shuff Jr.

(Address) Emmitsburg Md

15 Filed_____ 19____ Registrar

AUG 27 1927 C. HAMPSON JONES, M.D. Dep

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-25-27

17

I HEREBY CERTIFY, That I attended deceased from 7-26, 1927, to 8-25, 1927,

that I last saw him alive on 8-25, 1927,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Mastoiditis - left ear

following Acute Otaitis Media

Left ear. - Brain Abscess (duration) yrs. mos. 40 ds.

CONTRIBUTORY (Secondary) Brain Abscess

(duration) yrs. mos. ? ds.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? yes Date of 7-27-27 - Mastoidectomy 8-23-27 - Drainage of Brain Abscess

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Surgical

(Signed) A J Knapp, M. D.

8-25, 1927 (Address) Saint Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmittsburg Md Date of Burial Aug 28 1927

20 UNDERTAKER M. F. Shuff Son ADDRESS Emmittsburg Md

E

...stated EXACTLY. PHYSICIANS should state CAUSE ...don should be carefully supplied. AGE should be stated ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25035 ✓ E 25035

CERTIFICATE OF DEATH.

160

REGISTERED NO. 21-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hosp (ST.) (WARD)

2-FULL NAME Baby Boy Dean

(a) RESIDENCE No. 2771 W. Fairmount Ave ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 22'27

7 AGE — Years — Months — Days: 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Ollie Smith Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Esther Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Esther Dean
(Address) 2771 W. Fairmount Ave

15 Filed . 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 24 . 19 27 . to Aug 25 . 19 27 .

that I last saw h— alive on Aug 24 . 19 27

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Interstitial Hepatitis

(?) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical Findings

(Signed) W Neumeyer M. D.

. 19 (Address) 1013 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 26 1927

20 UNDERTAKER: H. B. Nippert — ADDRESS: 1800 W Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 25 1927 CHAS. N. JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 25036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 E 25036

REGISTERED NO.:
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hosp. ST. (or HOSPITAL) 14-20 WARD)

2-FULL NAME Mrs Bessie Armentrout

(a) RESIDENCE NO. 1734 Linden Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. A Armentrout

6 DATE OF BIRTH (month, day, and year): July 15 1883

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
44	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Geo. Armentrout

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Virginia Erman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Wayfield Record
(Address)

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 25 19 27

17 I HEREBY CERTIFY, That I attended deceased from 8-23-27, 19 , to 8-25-27, 19 ,
that I last saw her alive on 8-25-27, 19 ,
and that death occurred, on the date stated above, at 3 55 a. m.
The CAUSE OF DEATH* was as follows:

Uterine fibroma
Secondary Anaemia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Post Operative Shock.

(duration) yrs. mos. 6 hrs. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 8-25-27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Chas M. Hall, M. D.

. 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harrisonburg Va — DATE OF BURIAL: Aug 28 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Wait

AUG 27 1927 C. HAMPSON JONES, M. D. Registrar

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25037.

CERTIFICATE OF DEATH.

118-001

E 25037

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 West Balto. Gen. Hosp St. _____ Ward)

2-FULL NAME Mary L. Gannon

(a) RESIDENCE NO. 629 E. 30th St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilbur F. Gannon

6 DATE OF BIRTH (month, day, and year): Dec 24, 1870

7 AGE: Years 56 Months 8 Days _____ IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of Industry, business, or establishment in which employed (or employer): _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____

(State or country) Maryland

PARENTS

10 NAME OF FATHER John M Gordon

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Roy

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md

14 Informant W. F. Gannon

(Address) 629 E. 30th St.

15 Filed _____, 19 _____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Strangulated Hernia

(44)

(duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. T. Kennedy M. D.

(Coroner)

Aug. 25, 1927 (Address) 702 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death _____ yrs., _____ mos., _____ ds. In the State _____ yrs., _____ mos., _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. Date of Burial Aug 27 1927

20 UNDERTAKER: H. C. Cook ADDRESS 501 E. Lanvale

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Dr Knapp 1216 E Preston St

E 25038

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 25038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 30 West Southern Ave St., 77-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice L Abbott

(a) RESIDENCE No. 30 West Southern Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Jacob Abbott

6 DATE OF BIRTH (month, day, and year) Dec 18 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (At Home)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George M Gruskoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Gruskoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob Abbott

(Address) 30 W. Southern Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 1927

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1926. to Aug 23, 1927.

that I last saw h[illegible] alive on Aug 23, 1927.

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Abdominal Carcinoma

(Primary in Vagina)

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 1926

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Section

(Signed) Hubert E Knapp, M. D.

(Address) 1216 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Aug. 26 1927

20 UNDERTAKER J. H. Cook

ADDRESS 929 Linden Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Aug 26 1927 C. HOWARD JONES, M.D.

Spec.—1-12-23—M&T—500 Bks.

E 25039

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25039

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST 13-52 WARD)

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lang

(a) RESIDENCE NO. Florence Rittenden Home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

Years	Months	Days	If LESS than 1 day, hrs. or min.
(about 75 yrs)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ricardo

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 RHH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8- , 1927. to Aug-24 , 1927.

that I last saw h alive on Aug 27 , 1927.

and that death occurred, on the date stated above, at 12:50 P m.

The CAUSE OF DEATH* was as follows:

Pneumonic Bronchial

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Enteritis

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. E. Rollman, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aberdeen Md

DATE OF BURIAL Aug 29 1927

20 UNDERTAKER J. Fletcher Sons

ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25040

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25040

CERTIFICATE OF DEATH.

91-662

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 425 N Broadway (St.) 6-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Ritterhoff

(a) RESIDENCE NO. 425 N Broadway ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary W. Ritterhoff

6 DATE OF BIRTH (month, day, and year) Jan 31 - 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	83	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Candy Mfr

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Millman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Millman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant G H Ritterhoff (Address) 425 N Broadway

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1927, to Aug 23, 1927, that I last saw him alive on Aug 23, 1927, and that death occurred, on the date stated above, at 11 Pm.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phy Ex and Path

Signed Wm B Bades M. D.

Aug 24 19 27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 26 19 27

20 UNDERTAKER Wm J Uckher & Sons — ADDRESS 1208 Hav

Spec.–7-17-26—A Co.—200 Bks.

E 25041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46

E 25041

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Brown

(a) RESIDENCE NO. 239 Colvin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE Years 39 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Nelson Brown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Alberta Harris

(Address) 239 Colvin St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1927, to Aug 24, 1927, that I last saw h.er alive on Aug 24, 1927, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 8/18/27

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) J. E. Winstead M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedony Cemetery Date of Burial Aug 27 1927

20 UNDERTAKER Lucie M. Johnson ADDRESS 4167 W. Caroline St.

AUG 26 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25042

CERTIFICATE OF DEATH.

E 25042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205. N. Fulton ave St.; 14-27 WARD) 31

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles. Dantoni.

(Residence in Baltimore: No. 205. N. Fulton ave. St.; ....yrs., ...mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., (Month) (Day) 1897 (Year)

7-AGE, 30 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER Salvatore Dantoni

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Dora Dantoni

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Dantoni

(Address) 205 N. Fulton ave

15-

Filed AUG 26 1927 191.... HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 24, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1927, to Aug 25, 1927, that I saw him alive on Aug 24. 1927, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yr. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. 1 mos. ....ds.

(Signed) Thurlert C. Blake M. D.

8-25, 1927 (Address) 1014 N. Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral

DATE OF BURIAL, Aug 26 1927

20-UNDERTAKER Hamel Easton

ADDRESS 616 6a ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 25043 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 907 Warner St. 21-31 101 Ward)

Registered No.

2-FULL NAME Thelma McDonald

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 907 Warner St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Col	Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr-13-1925

7-AGE. 7 yrs. 4 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Child

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Baltimore
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Eddie Mitchell

11-BIRTHPLACE OF FATHER (city or town). Unknown
(State or Country).

12-MAIDEN NAME OF MOTHER. Carrie McDonald

13-BIRTHPLACE OF MOTHER (city or town). Norfolk Co.
(State or Country). Virginia

14-

(Informant). Carrie McDonald

(Address). 907 Warner St.

15-

Filed AUG 26 1927 R.H.M. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug-25-1927

17- I HEREBY CERTIFY, That I attended deceased from Aug-23 1927 to Aug 25 1927

that I last saw her alive on Aug-24 1927

and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) D. W. Strauchen M. D.

8/25 1927 (Address) 122 N Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
MT Auburn Cem	Aug 26 1927
20-UNDERTAKER. Daniel Easton	ADDRESS 916 Dolphin St.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

E 25044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 25044

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: BALTIMORE CITY HOSPITALS [redacted] St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Steward

(a) RESIDENCE NO. 412 E. 24th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, (Widowed) or Divorced, (write the word)
Female	Colored	Widowe

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-3-1857

7 AGE 70 Years 67 Months 8 Days 20 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Geo. Rankford

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Susan "

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant ?

(Address)

15 Filed ..... 19 .....

AUG 26 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-20, 1927, to 8-23, 1927.

that I last saw her alive on 8-23, 1927.

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis
arteris-sclerosis general
Gangrene, lower extremeties

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. Holmes Boyd, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the [redacted] Causing [redacted] From Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Loudon Cemetery 8-26-1927

20 UNDERTAKER — ADDRESS

Mrs Chas G. Bailey 1421 Jefferson St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 25045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 25045

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1931 Wilkens Ave St. 20-36 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Elmer Lee Oneale

(a) Residence No.... 1931 Wilkens Ave St., Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 4/92

7-AGE. 34 yrs. 10 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer)... iron foundry

(c) Name of employer... Reynolds

9-BIRTHPLACE (city or town). Glen Burnie (State or Country), Md

PARENTS.

10-NAME OF FATHER, Geo. W. O'Neale

11-BIRTHPLACE OF FATHER (city or town) Washington (State or Country), D.C.

12-MAIDEN NAME OF MOTHER, Mary L. Ronning

13-BIRTHPLACE OF MOTHER (city or town). Md. (State or Country),

11- (Informant) Helen Miller

(Address)... 1931 Wilkens ave

15- Filed AUG 26 1927 192 C. HAMPSON JONES, M. Registrar.

RRR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 24/27

17- I HEREBY CERTIFY, That I attended deceased from July 20, 1926, to Aug 24, 1926, that I last saw him alive on Aug 22, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis + nephritis

about 10

(Duration) yr. mo. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation + pulmonary hemorrhage

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H E Knipp M. D

Aug 25, 1927 (Address) 4025 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery DATE OF BURIAL. Aug 26, 1927

20-UNDERTAKER Harry A Wilke ADDRESS 1531 Lombard St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25046

CERTIFICATE OF DEATH.

114 E 25046

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 E. Montgomery ST. 22-33 WARD)

2-FULL NAME Sarah Emily Thomas

(a) RESIDENCE NO. 110 E. Montgomery ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of B. Frank Thomas

6 DATE OF BIRTH (month, day, and year) Jan 6, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER Perton

11 BIRTHPLACE OF FATHER (city or town) unknown. (State or country) Delaware

12 MAIDEN NAME OF MOTHER Cook

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co (State or country) Md.

14 Informant Mrs. Tracey Thomas

(Address) 116 E. Montgomery St.

15 Filed . 19 Registrar

C. HAMPSON JONES, M. D.

OCT 26 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1927, to August 25, 1927, that I last saw her alive on August 25, 1927, and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 0 yrs 1 mos 0 ds.

CONTRIBUTORY (Secondary) Gastro enteritis

(duration) 0 yrs 0 mos 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1319 Light St, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md, Via B.&A. RR	Aug 26 1927

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25047 ✓

CERTIFICATE OF DEATH.

129 E 25047

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 156 McHenry St. 20-69 WARD)

2-FULL NAME Daniel H. Kechner

(a) RESIDENCE NO. 156 McHenry St. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Kechner

6 DATE OF BIRTH (month, day, and year) Nov 17, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 -	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ottlob Kechner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Kumm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elisabeth M. Kechner

(Address) 156 McHenry St

15 Filed AUG 26 1927 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25 1927

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 1926. to Aug 25, 1927

that I last saw h in alive on Aug 25, 1927

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chr. Nephritis

Chr. Nephrosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) James Stowell, M. D.

, 19 (Address) Catonsville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 29 1927
20 UNDERTAKER	ADDRESS 532
George J. Smith	Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 25048

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 E 25048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1829 W. Fayette ST. 6-9 WARD)

2-FULL NAME Leonora C. Diror

(a) RESIDENCE NO. 1829 W Fayette ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 90 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15, 1837

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or min.
90	—	10	

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Edw. O. Grim

11 BIRTHPLACE OF FATHER (city or town) Fredk Co (State or country) Md

12 MAIDEN NAME OF MOTHER Amanda Orndorf

13 BIRTHPLACE OF MOTHER (city or town) Fredk Co (State or country) Md

14 Informant Oliver S. Diror

(Address) 715 Newington Ave

15 Filed ..... 19 .....

AUG 26 1927 C. HARRISON JONES, M. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to August 25, 1927, that I last saw her alive on Aug 25, 1927 and that death occurred, on the date stated above, at 11.58 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 1 hour ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Not known yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

(Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 27 1927
20 UNDERTAKER George J Smith	ADDRESS 1112 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25049

CERTIFICATE OF DEATH.

E 25049

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 107 E Heber ST. 74-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Schleef.

(a) RESIDENCE NO. 107 E Heber ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 21 1911

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
15	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Schleef.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marie Bowman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Henry Schleef. (Address) 107 E. Heber St.

15 Filed . 19 . Registrar

MAR 1927 C. HAMPSON JONES, M. Per RR K.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-23 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1927, to Aug 23, 1927.

that I last saw her alive on Aug 23, 1927,

and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Mitral Regurgitation

(duration) yrs. 6 mos 13 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

8-24-27 19 (Address) 107 East Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. DATE OF BURIAL: 8-27 1927

20 UNDERTAKER: E & T B Herle ADDRESS: 158 West Lo

Spec.—1-10-21—M&T—1500 Bks.

E 25050

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25050

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2300 Hunters 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Anderson

(a) RESIDENCE No. 2300 Hunters ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harwick Anderson

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Halifax Va

PARENTS

10 NAME OF FATHER Chester Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Halifax Va

12 MAIDEN NAME OF MOTHER Eliza Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Halifax Va

14 Informant Lewis S. Moore

(Address) 417 E 24th St.

15 Filed ..... 19 ..... RKK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 21, 1927, to Aug 23, 1927, that I last saw h[illegible] alive on Aug 23, 1927, and that death occurred, on the date stated above, at 4 A, m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri

(duration) 1 yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ' yrs. ' mos. ' ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of '

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8/26/27 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 8/26 1927

20 UNDERTAKER Pyzow & Wright

ADDRESS 1218 McElderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. E. 1927 E. BRAXTON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25051

CERTIFICATE OF DEATH.

3/ E 25051

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 N Eden ST. 39 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Osceola Edwards

(a) RESIDENCE NO. 719 N. Eden ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of Eugene Forbes

6 DATE OF BIRTH (month, day, and year) Aug 16th 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington N. C

PARENTS

10 NAME OF FATHER Joseph Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington N. C

12 MAIDEN NAME OF MOTHER Hattie Gainor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington N. C

14 Informant (Address) Ophelia Price 622 Monument St

15 Filed AUG 26 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 1927 to Aug 24 1927, that I last saw h.. alive on Aug 24 1927, and that death occurred, on the date stated above, at (2 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

Aug 29 27 (Address) 608 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington N. C

DATE OF BURIAL 8/27 1927

20 UNDERTAKER Pyson & Wright

ADDRESS 1218 McElderry St

Spec.—1-12-23—M&T—500 Bks.

Dr Diebel 1224 Hanover St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25052

CERTIFICATE OF DEATH.

101-001

E 25052

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2422 W Wilkens Ave (WARD) 21-64

2-FULL NAME William J Allen Jr.

(a) RESIDENCE No. 2422 W Wilkens Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 19 25

7 AGE: Years 2 Months 3 Days 6. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William J Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Delma V Heiland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: William J Allen

(Address): 2422 W Wilkens Ave

15 Filed Aug 27, 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21st, 1927 to Aug. 25th, 1927

that I last saw him alive on Aug. 24th, 1927

and that death occurred, on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Diarrhea & enteritis

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Special Examination

(Signed) D Bernard Diebel M.D.

(Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Aug 27 1927

20 UNDERTAKER: William Cahoon & Son

ADDRESS: Frankford

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25053

CERTIFICATE OF DEATH

113 E 25053

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. 18-24 St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Gibbs

(a) RESIDENCE NO. 921 Hollins st St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 10 - 1926

7 AGE: Years 9 Months 8 Days 15 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Anson Gibbs

11 BIRTHPLACE OF FATHER (City or town):

(State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Nellie Waltonan

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant: Anson Gibbs

(Address) 1826 McHenry

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1927, to Aug 25, 1927, that I last saw her alive on Aug 25, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Entero colitis

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) — yrs. — mos 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lewis Olds Jayne M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial: Aug 29 19 27

20 UNDERTAKER: William Cook — ADDRESS: 502 Eliza

IMPORTANT. This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Crummet

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001

CERTIFICATE OF DEATH.

E 25054
1-PLACE OF DEATH

REGISTERED NO. E 25054
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. Sinai Hospital St. 27-55 Ward)

2-FULL NAME Mrs Mattie Crummet

(a) RESIDENCE NO. 818 Hayward Ave St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elmer S Crummet

6 DATE OF BIRTH (month, day, and year): No 14- 1908

7 AGE: Years 28 | Months 9 | Days 12 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town):
(State or country) Va

PARENTS

10 NAME OF FATHER Clarence E Payne

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Va

12 MAIDEN NAME OF MOTHER Susie Perris

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Va

14 Informant Elmer S Crummet
(Address) 818 Hayward

15 Filed ..... 19 ..... A. M. .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Aug 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 17 1927, to Aug 26, 1927, that I last saw h.. alive on Aug 26, 1927, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:
Typhoid Fever

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (secondary) Lobar pneumonia, cellulitis in floor of mouth,

(duration) .....yrs. .....mos. .....ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 18

Was there an autopsy? Partial

What test confirmed diagnosis? Blood Culture Widall

(Signed) John A. Askew, M. D.
, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Orange Va — Date of Burial: Aug 26 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Ivan St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25055

CERTIFICATE OF DEATH

162 Tuesday

E 25055

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 So Thirteenth St. (If not in a hospital, give Ward) Nov 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bieger

(a) RESIDENCE NO. 515 So Thirteenth St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or ~~Divorced~~. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year): Aug 24-1927

7 AGE — Years — Months — Days: 2

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Bieger

11 BIRTHPLACE OF FATHER (City or town): Balto.

(State or country): Md.

12 MAIDEN NAME OF MOTHER: May Morschell

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country): Md.

14 Informant: John Bieger

(Address): 515 S. Thirteenth st.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/26 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 1927 to Aug 26 1927

that I last saw h[illegible] alive on Aug 25 1927

and that death occurred, on the date stated above, at 1.05 p.m.

The CAUSE OF DEATH* was as follows: Congenital debility

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) 61 E Lanvale

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Boughtman Cem. — Date of Burial: Aug 26 1927

20 UNDERTAKER: Tully & Zeller Co — ADDRESS: 403 E. Balto St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 1-25956 REGISTERED NO. E 25056

City of BALTIMORE: (No. 3926 Fernwood ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Mack.

(a) RESIDENCE NO. 3926 Fernwood ave St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible] Child

6 DATE OF BIRTH (month, day, and year): June 21-1923

7 AGE — Years: 4 Months: 2 Days: 4 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country) Md

PARENTS

10 NAME OF FATHER Charles Mack.

11 BIRTHPLACE OF FATHER (City or town): Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elsie Heinlein

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country) Md.

14 Informant: Elsie Mack.

(Address) 3926 Fernwood ave.

15 Filed AUG 26 1927 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: Aug 25. '27.

17 I HEREBY CERTIFY, That I attended deceased from Aug 1. 1927, to Aug 25 1927,

that I last saw her alive on Aug 25 1927,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. F. Burke, M. D.

Aug 26. 1927 (Address) 3042 Henderson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Oak Lawn Cem.	Aug 28 1927
20 UNDERTAKER	**ADDRESS**
Lilly & Zeiler	403 N. Wolfe

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 25057

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25057

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kiyozo Okuzawa

(Residence in Baltimore; No. Steamer Asuka Maru (Japan) St.: yrs., mos. 2 ds.)

2 days

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	single

6-DATE OF BIRTH, Feb 18 (Month) (Day), 1900 (Year)

7-AGE.	If LESS than 1 day,
26 yrs. 6 mos. 8 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Sailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Steamer Asuka Maru

9-BIRTHPLACE, (State or Country). Japan

PARENTS.

10-NAME OF FATHER, Mukuoan

11-BIRTHPLACE OF FATHER (State or Country). "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ramsay Scarlett & Co.

(Address) Calvert & Redwood Sts.

15-

Filed AUG 26 1927, 191.... HAMILTON JONES, M. D.

Per ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 26 (Month) (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Stroke Accident

Broken backbone & fractured skull - fell down hatchway to 4th or 5th deck - Taken to Mercy Hospital

(About 2 days) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] (Coroner) M. D.

Aug 26, 1927 (Address) 1639 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Aug 27, 1927

20-UNDERTAKER John O. Mitchell & Sons — ADDRESS 1300 Eutaw Place

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 25058 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25058

CERTIFICATE OF DEATH. 161-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. Balto Gen. Hosp ST. 13-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Bopkeal Gordon

(a) RESIDENCE No. 803 Lenox St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 20-1927

7 AGE: Years | Months | Days 5 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER David J. Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Celia Hann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hospital

15 Filed AUG 26 1927 Registrar H. C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 1927 to Aug 25 1927

that I last saw him alive on Aug 25 1927

and that death occurred, on the date stated above, at 2 A.M. p.m.

The CAUSE OF DEATH was as follows:

Cerebral Edema

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

8/26 1927 (Signed) Louis T. Law, M. D.

(Address) Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 8/26 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw St

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25059

CERTIFICATE OF DEATH.

161-004

E 25059

1-PLACE OF DEATH

City of BALTIMORE: (No. 1807 Hanover St. 23-32 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr. and Mrs. Samuel Grunger

(a) RESIDENCE NO. 1837 Hanover St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: White

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 26/27

7 AGE — Years | Months | Days | IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Samuel J. Grunger

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Louise Dreyer

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: Samuel J. Grunger

(Address): 1837 Hanover

15 Filed ..., 19...

AUG 26 1927 C. HAMPSON JONES, M. D.

Registrar

Undertaker

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 19 27, to Aug 26, 19 27, that I last saw h... alive on Aug 26, 19 27, and that death occurred, on the date stated above, at 8-30 A m.

The CAUSE OF DEATH* was as follows:

1 Premature birth

(duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

Signed) H. B. Campbell, M. D.

(Address) 1640 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

Date of Burial: Aug 19 27

20 UNDERTAKER: D. Schlosman & Son

ADDRESS 1034 Hanover

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Blks.

E 25060

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25060

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1739 Darley Ave St. 8-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adeline Harker

(a) RESIDENCE NO. 1739 Darley Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late James Harker

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
About	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Edward Rusk

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant Mrs. Annie Hartman

(Address) 1739 Darley Ave

15 Filed AUG 26 1927 19 C. HOWARD JONES, Registrar

By H. R. Bond

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 1926 to Aug 25 1927

that I last saw h[illegible] alive on Aug 24 1927

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac & Peripheral Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. E. Reese M. D.

Aug 25 1927 (Address) 1301 N Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Cemetery	Aug 27 1927
20 UNDERTAKER Henry Hasch Son	ADDRESS 1301 Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 5-17-26-A Co. 200 Bks.

E 25061

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25061

49

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3204 Greenmount Ave. St. 47-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James. R. Dunn

(a) RESIDENCE NO. 3204 Greenmount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 11 mos. 21 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mr Alice E. Dunn

6 DATE OF BIRTH (month, day, and year) September 5 1867

7 AGE	Years	Months	Days
	59	11	21

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER William E. Dunn

11 BIRTHPLACE OF FATHER (City or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosanna Bracton

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Mr. Alice E. Dunn

(Address) 3204 Greenmount ave

15 Filed AUG 26 1927, 19 C. HERBERT CONWELL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4th 1927, to Aug 26th 1927, that I last saw h[illegible] alive on Aug 25th 1927, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) yrs. 4 mos. 22 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial Aug 29 1927

20 UNDERTAKER Henry Hock Son ADDRESS 1301 E

(OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.—1-12-23—M&T—500 Bks.

Dr Stiblett 2220 Garrison Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25062

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

+90

REGISTERED NO. 25062

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2665 Pennsylvania Ave ST., 13 WARD)

2-FULL NAME Ellenora A. Frizzell

(a) RESIDENCE NO. 2665 Pennsylvania Ave ST., WARD 19

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Alfred W Frizzell

6 DATE OF BIRTH (month, day, and year) Dec 18 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER John Bollinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Harriett Showery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Alfred Frizzell (Address) 2665 Penna Ave

15 Filed ... 19 ... Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Aug 25, 1927, that I last saw h-r alive on Aug 25, 1927, and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

myocarditis

about 1 yr.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation Heart. about 12 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S Tillett, M. D.

Aug 26 1927 (Address) 2220 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olive Balto Co

DATE OF BURIAL Aug 29 1927

20 UNDERTAKER W. Cook

ADDRESS 502 E North Ave

AUG 29 1927 G. HAMPSON JONES, M. D.

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25063

CERTIFICATE OF DEATH.

84 E 25063

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1202 Cox St., 13-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Malachi L. Lee

(a) Residence No. 1202 Cox St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Lee

6-DATE OF BIRTH (month, day and year) Sept 1845

7-AGE. 81 yrs. 11 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Labor

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), N. C

PARENTS.

10-NAME OF FATHER, Edward Lee

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), N. C

12-MAIDEN NAME OF MOTHER, Julia Hardey

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), N. C

14- (Informant) Henry Lee

(Address) 1202 Cox St

15- Filed ..... 192.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 25 27

17- I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1927 to Aug 25, 1927, that I last saw him alive on Aug 25, 1927, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic Nephritis

..... (Duration) 1 yr. 6 mos. 7 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Hamilton, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means, and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mary Randolph DATE OF BURIAL. Aug 27, 1927

20-UNDERTAKER. A S Warfield ADDRESS 3539 Fall Rd.

Instructions on back of certificates.

AUG 25 1927 C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25064

CERTIFICATE OF DEATH

31 E 25064

1-PLACE OF DEATH

REGISTERED NO.

BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No.) St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Haines

(a) RESIDENCE NO. 1505 Eastern ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Haines

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE 38 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Warren Thomas

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Nancy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Hospital Record

(Address)

15 Filed , 19 Registrar

C. HAMILTON JONES, M. D.

AUG 26 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-22 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-27, 1927, to 8-22, 1927, that I last saw h[illegible] alive on 8-22, 1927, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hamilton Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va Date of Burial Aug 26 19 27

20 UNDERTAKER Samuel Heinsley ADDRESS 1700 Bolton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25065

CERTIFICATE OF DEATH

E 25065

1-PLACE OF DEATH

City of BALTIMORE: (No. 3005 Frederick ave St. 20-69 Ward)

REGISTERED NO. 48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella B. Young

(a) RESIDENCE NO. 3005 Frederick ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo C. Young

6 DATE OF BIRTH (month, day, and year) June 5-1863

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Martinsburg

(State or country) W. Va.

PARENTS

10 NAME OF FATHER Richard Henry Davis

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Martinsburg W. Va

12 MAIDEN NAME OF MOTHER Anna Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto md

14 Informant Thos Davis

(Address) 1615 E. Oliver St

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug 25 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to Aug 25, 1927, that I last saw her alive on Aug 24, 1927, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal disease

Edema of Lungs (2 days)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of face

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. L. Liechtenberg M. D.

8/26/1927 (Address) 1111 W Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial Aug 29 1927

20 UNDERTAKER Josiah Dyer

ADDRESS 1400 W North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 25066

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25066

CERTIFICATE OF DEATH

REGISTERED NO. 74-004

1-PLACE OF DEATH

City of BALTIMORE: (No. Southern Hospital St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine B. Baytop 35 E Fremont ave

(a) RESIDENCE NO. Southern Hospital St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christopher Baytop

6 DATE OF BIRTH (month, day, and year) 1837

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westpoint

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Styron

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Octavia C. Hill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Mr. Elphinstone

(Address) 206 Upper Road

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

August 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1927, to Aug 25, 1927, that I last saw her alive on Aug 25, 1927, and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W. W. Wyman, M. D.

8/26/27 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westpoint, Virginia

Date of Burial Shipment 8/26/27 19

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W. Baltimore St

D 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25067

CERTIFICATE OF DEATH.

31 E 25067

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 540 Wilson St. 14-20 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Smith

(a) RESIDENCE NO. 540 Wilson St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 1, 1910

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	17	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Owen Smith

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Washington

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Ruth Smith

(Address) 540 Wilson St

15 Filed ____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1927, to Aug 25, 1927, that I last saw her alive on Aug 24, 1927, and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 6 mos.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

Aug, 1927 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Aug 28 1927

20 UNDERTAKER — ADDRESS

Geo. T. A. Gibson 1135 Lanvale

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25068

CERTIFICATE OF DEATH.

E 25068

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Aged Womens Home

CITY OF BALTIMORE: (No. 1400 W Lexington ST. 9-27 WARD)

2-FULL NAME Emma V Welshoffer

(a) RESIDENCE NO. 1400 W Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William H Welshoffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Ella Z Jones
(Address) 1400 W Lexington St

15 Filed ..., 1927 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1927, to Aug 25, 1927, that I last saw her alive on Aug 23, 1927, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Feeble Heart action due to advanced age

(duration) yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Duncan, M. D.

(Address) 5106 Ford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 27 1927

20 UNDERTAKER George J Smith ADDRESS 532 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25069

CERTIFICATE OF DEATH.

188-08

E 25069

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH B. & O. R. R. Co. Yards

City of BALTIMORE: (No.____ Locust Point. St. 16-7th Ward)

2-FULL NAME Thomas H. Alexander.

(a) RESIDENCE NO. 1048 W. Fayette St. St.____ Ward____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ____ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

3a If married, widowed, or divorced, HUSBAND of (XXXXXXXXX) Margaret Alexander.

6 DATE OF BIRTH (month, day, and year) December 20, 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Inspector.

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town)____

(State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER John B. Alexander.

11 BIRTHPLACE OF FATHER (city or town)____

(State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Susan Boston.

13 BIRTHPLACE OF MOTHER (city or town)____

(State or country) Pennsylvania.

14 Informant Charles G. Alexander. (son)

(Address) 808 Pierson St. Newcastle Pa.

15 Filed____ 19____ DRH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed about the body.
Accidentally run over by car of
B. & O. R. R. Co.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Wm. Leonard M. D.
(Coroner)

8/27 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the state....yrs....mos....ds.

Where was disease contracted, if not at place of death?____

Former or usual residence____

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Castle Pa. Date of Burial 8/29 1927

20 UNDERTAKER Schultz & Cole ADDRESS 1416 Bolton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 29 1927 C. HAMILTON JONES, M. D.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25070 E 25070

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 N. Gay St.) (8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Eggs

(Residence in Baltimore: No. 1810 N Gay St St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, June (Month) 17 (Day), 1854 (Year)

7-AGE 73 yrs. 2 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Baker

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Hale Eggs

(Address) 1810 N. Gay St

15-

Filed....., 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 26 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8—25 1927 to 8—26 1927, that I saw h[illegible] alive on 8—25 1927 and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Nephritis, Arteriosclerosis
..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) Chas Hale Eggs M. D.

8-27, 1927 (Address) 1810 N. Gay St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Aug. 28 1927

20-UNDERTAKER Peter & Nicolaus — ADDRESS 2983 Easton

Spec.—1-12-23—M&T—500 Bks.

E 25071 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25071

1-PLACE OF DEATH

CITY OF SALTIMORE: (No. 602 S. Kenwood ave ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George P. J. Schehlein

(a) RESIDENCE NO. 602 S. Kenwood ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Schehlein

6 DATE OF BIRTH (month, day, and year) Jan. 8-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	68	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Skilled Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Gas + Elec. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Michael Schehlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosanna Volker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Schehlein

(Address) 602 S. Kenwood ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26th 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1926, to Aug 26 1927, that I last saw him alive on July 10, 1927 and that death occurred, on the date stated above, at 8 9 m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. L. Rucker, M. D.

19 (Address) 408 Bad Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL Aug 29 1927

20 UNDERTAKER George W. Zinkler — ADDRESS 1737 E. Eager St.

AUG 27 1927 C. HAMPSON JONES, M. D.

Read carefully important—See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25072

CERTIFICATE OF DEATH.

161-001 E 25072

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2209 Gough St., 13 Ward)

2-FULL NAME Baby Beverungen

(a) RESIDENCE NO. 2209 Gough St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 24, 1927

7 AGE: Years | Months | Days: 2 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): 2209 Gought.

(State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Otto Beverungen

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Balto Md

12 MAIDEN NAME OF MOTHER Isabell Miller

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Balto Md

14 Informant: Otto Beverungen

(Address): 2209 Gough St.

15 Filed ..... 19 ..... RPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 1927 to Aug 26, 1927, that I last saw h[illegible] alive on Aug 26, 1927, and that death occurred, on the date stated above, at 2300 m.

The CAUSE OF DEATH* was as follows:

Pneumonia, duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (5 months) Pertussis.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C. S. & L.

(Signed) John J. Kruger, M. D.

, 19 (Address) 5627 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial

Forest Lawn Cemetery Aug 27 1927

20 UNDERTAKER: Lilly & Zeiler Co ADDRESS 4038 Old Wolfe

Property classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Lina Tiller

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25073 E 25073

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1208 E. Madison 10-14 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lina Tiller

(a) RESIDENCE NO. 1208 E. Madison WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Coleman

6 DATE OF BIRTH (month, day, and year): May 6 1903

7 AGE: Years 24 | Months 3 | Days 20 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Island Md.

PARENTS

10 NAME OF FATHER: James Meredith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ida Brann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Ida Jones 1208 E. Madison

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 28 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1927, to Aug 28, 1927.

that I last saw her alive on Aug 28, 1927

and that death occurred, on the date stated above, at 4.45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. 7 mos 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kent Island Md — DATE OF BURIAL: Aug 29 1927

20 UNDERTAKER: Mrs Ida Crowder — ADDRESS: 1208 E. Madison

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25074 — E 25074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 16-006

City of BALTIMORE: (No. 1146 Calhoun St.) 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Eskridge

(a) Residence No. 1146 calhoun St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Femal

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced (write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): August 22/927

7-AGE: yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: nn

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto City Md.

PARENTS

10-NAME OF FATHER, Hunit Holley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Hannis Eskridge

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-(Informant) Fannie Eskridge

(Address) 1146 Calhoun St

15-

Filed 1927 192

C. HAMPTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 8-26-27

17-I HEREBY CERTIFY, That I attended deceased from Aug 24, 1927 to Aug 25, 1927 that I last saw her alive on 8-25-27, and that death occurred, on the date stated above, at 7 AM

The CAUSE OF DEATH* was as follows:

Amoebic Dysentery

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Teething

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 1146 Calhoun

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Aug 27, 19 27

20-UNDERTAKER: Druid Easton — ADDRESS 916 Dame.

instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 25075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001

E 25075

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Henry Lang

(a) RESIDENCE NO. Ramsey st near Ringgold st St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred all life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single, Married, Widowed,~~ or Divorced. (write the word): Divorced

5a If ~~married, widowed,~~ divorced HUSBAND of (or) ~~WIFE of~~: Jane Lang

6 DATE OF BIRTH (month, day, and year): May 14 1878?

7 AGE: Years 49? Months 3 Days 11 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hospital Attendant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer City Hospital

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant (Address) Baltimore City Hospitals

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 22, 1927, to Aug 25, 1927, that I last saw h.. alive on Aug 24, 1927, and that death occurred, on the date stated above, at 8.40 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Starvation and post operative depression Psychosis

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 1927

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Philip Pearlstein, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial 8/29/27

20 UNDERTAKER: Geo Leimbach & Son ADDRESS: 822 N. Eutaw

OF DEATH in plain terms. So that it may be very important. See instructions on back of

1927 C HAVEN JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

E 25076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25076

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. J. H Hospital St. 7-13 Ward)

2-FULL NAME Sallie M. Wilkins

(a) RESIDENCE NO. 1801 E. Madison St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Feb 2 — 1920

7 AGE — Years: 6 — Months: 4 — Days: 25 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer): _____

(c) Name of employer: —

9 BIRTHPLACE (city or town) _____ (State or country) Va

PARENTS

10 NAME OF FATHER Early Wilkins

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Va

12 MAIDEN NAME OF MOTHER Fannie Carter

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Va

14 Informant Early Wilkins (Father) (Address) 1801 E Madison St

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Coroner, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Duration ..... yrs. 1 ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

Duration ..... yrs. ..... mos. ..... ds.

Attended ..... (Coroner) ..... M. D.

(Address) 4361 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Farmville Va — Date of Burial: Aug 27 1927

20 UNDERTAKER: Robert E. Wilkins — ADDRESS: 1515 McElderry St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Connors

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25077

CERTIFICATE OF DEATH

31 E 25077

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals (Name) St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Connors

(a) RESIDENCE NO. 202 Albemarle st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Connors

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Lane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

C. HERBERT JONES, M. D.

8-27-1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 August 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 16, 19 27, to August 22, 19 27, that I last saw him alive on August 22, 19 27, and that death occurred, on the date stated above, at 11.25 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. C. Maddox, M. D.

8-23-19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Sacred Heart	8-27-1927
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	1318 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Frank A Bauml

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25078

E 25078

90

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS 4-30

City of BALTIMORE: (No. [redacted] St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A Bauml

(a) RESIDENCE NO. 638 W. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 (Single), Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 79 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer): 017

(c) Name of employer

9 BIRTHPLACE (city or town): austria

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country): austria

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): austria

14 Informant

(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24 1927

17 I HEREBY CERTIFY, That I attended deceased from 2-3, 1925, to 8-24, 1927

that I last saw him alive on 8-24, 1927,

and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Chr. myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. findings

(Signed) C. Stevenson Boyd, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — Date of Burial 8-27-1927

20 UNDERTAKER: J. J. Fahey & Sons — ADDRESS 1318 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25079

CERTIFICATE OF DEATH.

161-001

E 25079

1-PLACE OF DEATH

City of BALTIMORE: (No. 412 Ensor St. 10-14 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Russo

(a) RESIDENCE NO. 912 Ensor St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 24, 1927

7 AGE: Years ___ Months ___ Days 2 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: Augustine Russo

11 BIRTHPLACE OF FATHER (city or town): Italy

(State or country)

12 MAIDEN NAME OF MOTHER: Carmella Difranck

13 BIRTHPLACE OF MOTHER (city or town): Italy

(State or country)

14 Informant: Augustine Russo

(Address): 912 Ensor

15 Filed _____ 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 26 19 27

17

I HEREBY CERTIFY, That I attended deceased from Aug 24 19 27 to Aug 26 19 27,

that I last saw h__ alive on Aug 26, 19 27,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Premature baby - 6 mo -

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leon Greenwood, M. D.

Aug. 19 27 (Address) 1809 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents — Date of Burial: 8/27 1927

20 UNDERTAKER: Hamel Corcoran — ADDRESS: 1906 Eutaw

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 25080

CERTIFICATE OF DEATH.

129 E 25080

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 N Conway St. Ward)

2-FULL NAME Virgie Green

(a) RESIDENCE NO. 614 N. Conway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Green

6 DATE OF BIRTH (month, day, and year) 1902 May 15

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or....min.
	25	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) S C

PARENTS

10 NAME OF FATHER Richard Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S C

12 MAIDEN NAME OF MOTHER Adel Pryed

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S C

14 Informant Louis Green (Husband)

(Address) 614 N Conway St

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

Screen and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

AC Hopkins

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ..... yrs. 9 mos. 1 ds.

(Signed) G H Simpson Jones M. D.

(Coroner)

19 (Address) 1473 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Georgetown SC	aug 27, 19 27

20 UNDERTAKER J Leon Hall ADDRESS 753 Dolphin St

Of importance in preparing records, so that it may be possible to secure information if certificate is lost. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 25081

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Eliz ST., 7-13 WARD)

2-FULL NAME Mrs Ella C. Krastel

(a) RESIDENCE NO. 1035 Mc Henought ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female.	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Krastel

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John. H. Merrick —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Louisa Seconfd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Peter Krastel.

(Address) 1035 McHenough St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 19 27, to Aug 26, 19 27, that I last saw her alive on Aug 26, 19 27, and that death occurred, on the date stated above, at 10:10 p m.

The CAUSE OF DEATH* was as follows:

Dermoid Cyst of Ovary — with Carcinomatous Change.

Chr. Myocarditis (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of 8/26/27

Was there an autopsy? none.

What test confirmed diagnosis? Clinical —

(Signed) J. P. Thompson, M. D.

, 19 2/ (Address) St. Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Aug 30 1927

20 UNDERTAKER Henry Hoech Son

ADDRESS 1301 E Eager

THIS IS VOID UNLESS FILLED IN. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 25082

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 E 25082

CERTIFICATE OF DEATH

1-PLACE OF DEATH — Hamilton

City of BALTIMORE: (No. 11 Batavia Ave St. 27-44 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Boettger

(a) RESIDENCE NO. 11 Batavia Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mr Ellis Boettger

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 78 Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER Carl Beyer

11 BIRTHPLACE OF FATHER (City or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs Elsie Rivemont

(Address) 11 Batavia Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/24, 1927, to 8/26, 1927, that I last saw h alive on 8/26, 1927, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hyde W. Allen M. D.

8/26, 1927 (Address) 5012 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Date of Burial: Aug 29 1927

20 UNDERTAKER: Henry Houck Son ADDRESS: 1300 E Eager

If DEATH in plain view, or that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25083

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

3-5-90

E 25083

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 711 S. High St. WARD)

2-FULL NAME Anthony Pernicola

(a) RESIDENCE No. 711 S High. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rose. T. Pernicola.

6 DATE OF BIRTH (month, day, and year) 25 June-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	65	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City-

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Dominick Brow

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER ~~Rose~~ T. Mouthrow

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Miss E. Pizza
(Address) 711 S. High-

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26/27 19

17

I HEREBY CERTIFY, That I attended deceased from 10/26/26, 19 to 8/26/27, 19,

that I last saw him alive on 8/25/27, 19,

and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Gaudese, M. D.

8/27/27 19 (Address) 321- E- 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Aug 29 19 27

20 UNDERTAKER Wendell Dypsel & Son — ADDRESS 37 Lan

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25084

CERTIFICATE OF DEATH.

E 25084

91-50

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Asbury Rd (St.) Mt Pleasant (Ward) 54

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caleb O. Williams

(a) RESIDENCE No. Asbury Rd (St.) Mt Pleasant Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mary E. Williams

6 DATE OF BIRTH (month, day, and year): Sept 11 1845

7 AGE: Years 81 Months 11 Days 14 If LESS than 1 day, hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co

PARENTS

10 NAME OF FATHER: John O Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co.

12 MAIDEN NAME OF MOTHER: Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant (Address): Mrs Williams Asbury Rd

15 Filed AUG 29 1927, 19 . C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10 1927, to Aug. 25 1927, that I last saw h— alive on Aug 25 1927, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Senile degeneration

cerebro Cerebris

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. H. Bleeker M. D.

8.26, 1927 (Address) 727 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hanover

DATE OF BURIAL: Aug 29 1927

20 UNDERTAKER: A S Marshall

ADDRESS: 2537 Frederick Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

26 S-604 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25085

CERTIFICATE OF DEATH.

† 71-001 E 25085

REGISTERED NO.

1-PLACE OF DEATH [illegible] HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. [illegible] ST., 1-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbain H Means

(a) RESIDENCE No. 53 Sassy Cliff ST., WARD Houston Texas
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 8 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	20	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Houston Texas
(State or country)

PARENTS

10 NAME OF FATHER I. Means

11 BIRTHPLACE OF FATHER (city or town) La.
(State or country)

12 MAIDEN NAME OF MOTHER Stella Bonner

13 BIRTHPLACE OF MOTHER (city or town) Texas
(State or country)

14 Informant Records

(Address) [illegible] HOPKINS HOSPITAL

15 Filed . . . . , 19 . . . . Registrar RLL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to August 28, 1927, that I last saw him alive on August 28, 1927, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Brain abscess, frontal
secondary to frontal
sinus infection

(duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Meningitis (non epidemic)

(duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death? At place of birth

Did an operation precede death? Yes Date of July 22, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. D. Hart M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Houston, Texas	Aug 29 1927

20 UNDERTAKER John C Mitchell & Sons ADDRESS 1900 Eutaw Pl

Cor.--12-9-25—A Co.—200 Bks.

E 25086 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. E 25086

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Union Memorial Hospital St. 4 Ward)

2-FULL NAME Wallace Henry Harker

(a) RESIDENCE NO. 407 Hawthorne Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura

6 DATE OF BIRTH (month, day, and year): 10-26-49

7 AGE: Years 77 Months 10 Days 5

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER: Henry Harker

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Troell

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country) Md

14 Informant: Mrs. Mitchell Baxter

(Address) Catonsville

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (autopsy or inquest) thereon and from the evidence obtained by said Inquest (autopsy or inquest) and from the evidence obtained by said autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cardiac Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Morrison M. D.

(Corner) 8/27, 1927 (Address) 5624 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.,..... mos.,..... ds. In the State..... yrs.,..... mos.,..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Date of Burial: Aug 29 1927

20 UNDERTAKER: J. M. Cook ADDRESS: 507 E. North Ave.

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Dr Flury 910 N Lombard St

E 25087 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-09 E 25087

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 702 Portland St ST. 22-30 (WARD)

2-FULL NAME Ella E Rush

(a) RESIDENCE NO. 702 Portland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced (a) HUSBAND of (a) WIFE of Arthur A Rush

6 DATE OF BIRTH (month, day, and year) July 12 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	53	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Decker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ellen T Annible

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Arthur A Rush 702 Portland St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 19 1927 to Aug 26 1927 that I last saw h alive on Aug 26 1927 and that death occurred, on the date stated above, at 9:10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis Hypertension

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexy (Cerebral)

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Diagnosis

(Signed) Chas A Carlton M. D.

8/26 1927 (Address) 2105 N Bells Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wood Lawn DATE OF BURIAL Aug 30 1927

20 UNDERTAKER J M Cook ADDRESS 503 E Baltimore

Spec.—1-12 23—M&T—500 Blks.

E 25088 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 E 25088

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2237 Fremont St. 8-12 WARD)

2-FULL NAME Bertha Lloyd

(a) RESIDENCE No. 2237 Fremont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lloyd

6 DATE OF BIRTH (month, day, and year) June 20 76

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Mc Kinnon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mc Kinnon

12 MAIDEN NAME OF MOTHER Mc Kinnon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mc Kinnon

14 Informant Mrs Edwin Cases

(Address) 2237 Fremont Ave

15 Filed Aug 27, 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 7 —, 1927, to Aug. 26—, 1927, that I last saw h[illegible] alive on " ", 1927, and that death occurred, on the date stated above, at 2—5 P.M. The CAUSE OF DEATH* was as follows:

Carcinoma of the Rectum

(duration) 1 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 1926

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenton M. D.

Aug 27, 1927 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Aug. 29 DATE OF BURIAL 1927

20 UNDERTAKER J. W. McCormick & Co ADDRESS [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 25089

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25089

CERTIFICATE OF DEATH.

161-001

16-27

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 W. Fulton Ave ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosemary Griffin

(a) RESIDENCE. No. 604 W. Fulton Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS VERY important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wh	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 25/27.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George J. Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Regina Lang.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburgh Pa.

14 Informant (Address) Mr. George Griffin 604 W. Fulton Ave.

15 Filed AUG 28 1927 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1927 to Aug. 27 1927

that I last saw her alive on Aug. 26 1927

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity
(6½ mo.)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Maurice E. Shamon M. D.

8/27 1927 (Address) 3300 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 29 1927
20 UNDERTAKER	ADDRESS
F. A. Schauer & Son	703 Hamilton Ave

Cor.—12-9-25—A Co.—200 Bks.

E-25090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25090

1-PLACE OF DEATH — REGISTERED NO._____

City of BALTIMORE: (No. Jenkins Memorial St. Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank E. Monroe

(a) RESIDENCE NO. 544 E. 22nd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Monroe

6 DATE OF BIRTH (month, day, and year) Jan 1st 1867

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farming Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Thos. Monroe

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Julia A. Rogers

13 BIRTHPLACE OF MOTHER (City or town) Va

(State or country)

14 Informant Elizabeth M. Monroe

(Address) 544 E. 22nd St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd Degree burns Covering most of Body accidentally Caught on fire

Paralysis of Entire R. Side (duration) yrs. mos.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D. (Coroner)

Aug 26 1927 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial Aug 29th 1927

20 UNDERTAKER Chas. G. Black ADDRESS 742 W Fayette St

very important. See instructions on back of certificate.

Spec.—12-9-25—2 Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ **E 25091**

E 25091
1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 2817 St Paul St. 12-50 Ward)

2-FULL NAME Mary Olevia Kirk

(a) RESIDENCE NO. 2817 St Paul St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 16 1852

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	74	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Baltimore Md

(State or country) Maryland

PARENTS

10 NAME OF FATHER James G. Kirk

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Switzer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Miss Norma E. Kirk

(Address) 2817 St Paul St.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3 1927, to Aug 26, 1927, that I last saw h[illegible] alive on Aug 26, 1927, and that death occurred, on the date stated above, at 8.08 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 7 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute hilot[illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted 2817 St. Paul,

if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) James C. Clarke, M. D.

8/7, 1927 (Address) 2a Cathedral Apt. Charles and 54

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Park Cemetery Date of Burial: Aug 29 1927

20 UNDERTAKER: Chas. G. Black ADDRESS: 742 W. North ave

AUG 29 1927 C. HARVEY JONES, M. D.

RLK

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25092

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 25092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3636 Sycamore ST. (WARD) 57

2-FULL NAME Oscar Hoy Jr

(a) RESIDENCE NO. 3636 Sycamore ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Aug 26 1927

7 AGE Years Months Days If LESS than 1 day 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Oscar Hoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jennie Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Oscar Hoy

(Address) 3636 Sycamore st

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26 — 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/26, 1927, to 8/26, 1927, that I last saw h[illegible] alive on 8/26, 1927, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows: Congenital Heart

of 7 1/2 Months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Medical Facts

(Signed) C. Hurdle, M. D.

, 19 (Address) 1340 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hompda

DATE OF BURIAL Aug 29 1927

20 UNDERTAKER Chenoweth & Son

ADDRESS 3615 Old Frederick Rd

Spec.—12-9-25—A Co.—200 Bks.

E 25093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59-003

E 25093

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1408 Battery Av St. 24-34 Ward)

2-FULL NAME Helen May Stone

(a) RESIDENCE NO. 1408 Battery Av St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. 29 ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 7.30. 1927

7 AGE — Years | Months | Days: 29 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Walter Henry Stone

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Mary S. Skinner

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Washington DC

14 Informant Mrs May Stone

(Address) 1408 Battery Av

15 Filed ____ 19____ RWK • Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8.27. 1927

17 I HEREBY CERTIFY, That I attended deceased from 7.30 1927, to 8.27 1927, that I last saw her alive on 8/27 1927, and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Spina Bifida

CONTRIBUTORY (Secondary) Gen Sepsis (duration) ____ yrs. ____ mos. 29 ds.

(duration) ____ yrs. ____ mos. 29 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) L. P. Worthington, M. D.

, 19 (Address) 102 E Fort Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — Date of Burial: 8/29 1927

20 UNDERTAKER: J. Flew McCully — ADDRESS: 130 E Fort

Very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 25094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 1

E 25094

REGISTERED NO.

1-PLACE OF DEATH Evergreen Terrace

City of BALTIMORE: (No. 2712 Evergreen Terrace Ward) Feb 13-39

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard L. B. Keller

(a) RESIDENCE NO. 2712 Evergreen Terrace St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 3 mos. 14 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna R. Keller

6 DATE OF BIRTH (month, day, and year) May 21 — 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	63	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Andrew J. Keller

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Ryan

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Baltimore Md

14 Informant Howard Keller

(Address) 2712 Evergreen Terrace

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27 — 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1924, to August 27, 1927.

that I last saw him alive on August 25, 1927.

and that death occurred, on the date stated above, at 3.40 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 23-1925

Was there an autopsy? no

What test confirmed diagnosis? Section removed & Examined

(Signed) Charles Riel Edmonds, M. D.

8/27/27 (Address) 214 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Druid Ridge Cemy. — Date of Burial Aug 29 19 27

20 UNDERTAKER John C. Mitchell & Sons — ADDRESS 1900 Eutaw Pl.

very important. See instructions on back of certificates.

AUG 29 1927 H. [illegible] James M.D.

Spec.—8-24-14—M. & T.—2000 Bks.

E 25095

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 25095

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 242 N. Milton Ave ST.; 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Akers

(Residence in Baltimore: No. 242 N. Milton Av St.; 44 yrs., 11 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Married

6-DATE OF BIRTH, Sept — 1 —, 1881
(Month) (Day) (Year)

7-AGE, 45 yrs. 11 mos. 26 ds. 25

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electric Welder
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Daniel L Akers

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jennie Browning

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine E. Akers

(Address) 242 N. Milton Ave

15-

Filed ..... 191.....

AUG 29 1927 HAMILTON JONES, M. D.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug — 26, 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1927, to Aug 25 1927, that I saw him alive on Aug 25 1927, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis

Duration 11 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

Duration 1 yrs. 1 mos. ds.

(Signed) J. B. Hughes M. D.

Aug 26, 1927 (Address) 1443 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Calvert Cemetery

DATE OF BURIAL, Aug 29, 1927

20-UNDERTAKER Wm. C. Millard & Son

ADDRESS 2534 Jefferson

Spec.—1-12-23—M&T—500 Bks.

Graham.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25096

CERTIFICATE OF DEATH.

E 25096

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPT. St. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Graham.

(a) RESIDENCE No. 310 Orm Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town here death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Baby

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-8-27

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4 mos	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bolto Md.

PARENTS

10 NAME OF FATHER Mitchell Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Parents (Address) JOHNS HOPKINS HOSPT.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23 . 19 27 . to Aug 26 . 19 27 .

that I last saw h alive on Aug 26 . 19 27 .

and that death occurred, on the date stated above, at 8.00 P m.

The CAUSE OF DEATH* was as follows:

Acute G.I. Indigestion
& Acidosis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) [signature], M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery

DATE OF BURIAL aug 29 1927

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45

E 25097

1-PLACE OF DEATH

REGISTERED NO. E 25097

City of BALTIMORE: (No. Balto City Hospitals St., 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hammond

(a) RESIDENCE NO. 1244 N Carlton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~eighteen~~ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~eighteen~~

7 AGE: Years 32 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Joseph Hammond

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Sarah Sugars
(Address) 1244 Carlton St.

15 Filed ..... 19 ..... C. [illegible] M. D.
AUG 29 1927 Registrar
Per R L K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
August 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from
Aug. 24, 1927 to Aug 26, 1927.
that I last saw ~~him~~ alive on August 26, 1927
and that death occurred, on the date stated above, at 8:9 a.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
with metastasis
Multiple Abscesses ..... duration ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death? Home
Did an operation precede death? Yes Date of [illegible]
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.
. 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: Aug. 29 1927

20 UNDERTAKER: Mrs Katie R. Williams — ADDRESS 324 N. Schroeder St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25098

CERTIFICATE OF DEATH.

E 25098

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5024 Thornton Ave ST., 15-60 WARD)

2-FULL NAME Henry William Herman

(a) RESIDENCE NO. 1709 Moreland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa D. Herman

6 DATE OF BIRTH (month, day, and year) Mar. 17 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	86	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. John G. Herman (Address) 3515 Springdale Ave.

15 Filed ..... 19..... Registrar

AUG 29 1927 C. HAWKINS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 25th, 1927, to Aug 27th, 1927, that I last saw h[illegible] alive on Aug 27th, 1927, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. 3 mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hinkle M. D.

, 19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL Aug 29 1927

20 UNDERTAKER Wm J Fickus & Sons ADDRESS Govd Rd

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 V

E 25099

CERTIFICATE OF DEATH

E 25099

REGISTERED NO.

1-PLACE OF DEATH Balto City Hospitals

City of BALTIMORE: (No. Balto Md. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hall

(a) RESIDENCE NO. 428 Fawcett St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 19 1882

7 AGE — Years: 45 — Months: 5 — Days: 8 — IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Boiler
(b) General nature of industry, business, or establishment in which employed (or employer): Inspector
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Maryland

PARENTS

10 NAME OF FATHER: George B. Hall

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Arey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Maryland

14 Informant (Address): Balto City Hospitals Balto Md.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-27-27

17 I HEREBY CERTIFY, That I attended deceased from 7-20- 1927, to 8-27, 1927 that I last saw him alive on 8-27, 1927, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted? Unknown
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Serological & Clinical

(Signed) Henry Fitzhugh M. D.

5/29/27 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden — Date of Burial: 5/30 1927

20 UNDERTAKER: J Walter Davis — ADDRESS: 3307 Hamilton

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

y05787

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25100

CERTIFICATE OF DEATH.

E 25100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell Reinisch

(a) RESIDENCE NO. 700 S-Ilosen ST., WARD City

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. — mos. — ds. How long in U. S., if of foreign birth? life yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 1926.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Carroll Reinisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Margaret Schrader

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Reads -

(Address)

15 JOHNS HOPKINS HOSPITAL.

Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1927, to Aug 26, 1927, that I last saw him alive on Aug 26, 1927, and that death occurred, on the date stated above, at 10 10 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Pertussis

(duration) yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Enteritis

(duration) yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hosp

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel Cem

DATE OF BURIAL Aug 29 1927

20 UNDERTAKER Stephen J Galsworth

ADDRESS Hyattsville

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25101

CERTIFICATE OF DEATH

E 25101

1-PLACE OF DEATH

City of BALTIMORE: (No. German Aged Home St. Baltimore and Payson Streets Ward) 70-27 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Zook Mast

(a) RESIDENCE NO. German Aged Home St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June, 4th. 1844

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	82	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Co.

(State or country) Pa.

PARENTS

10 NAME OF FATHER Daniel K Mast

11 BIRTHPLACE OF FATHER (City or town) Lancaster Co.

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Zook

13 BIRTHPLACE OF MOTHER (city or town) Lancaster Co

(State or country) Pa.

14 Informant Records German Aged Home

(Address) Baltimore & Payson Streets

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August, 27" 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1927, to Aug. 27, 1927, that I last saw him alive on Aug. 25, 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Lobar Pneumonia, Bilateral

(duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Wm. K. Johnson, M. D.

(Address) 1206 St. Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Long Green Md. Date of Burial Aug. 30" 1927

20 UNDERTAKER Joseph L Cook ADDRESS 1003 N. Balto St

very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25102

CERTIFICATE OF DEATH.

101-001 E 25102

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 N. Charles St 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frieda Gross

(Residence in Baltimore: No. 100 N. Charles St

St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1858 (Year)

7-AGE, 72 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Nathan Schochet

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nathan Levinson

(Address) 29 N. Patt. Pk. Ave.

15-

AUG 29 1927 BALTIMORE, MD.

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 28th, 1927 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1927, to Aug 28th 1927, that I saw her alive on Aug 28th 1927, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

.....

.....

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Benjamin Rubinow M. D.

Aug 29, 1927. (Address) 1804 Eutaw pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Cemetery — DATE OF BURIAL, 8-29-, 1927

20-UNDERTAKER Jack Levin, 1439 — ADDRESS E. Baltimore St

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

138

E 25103
1-PLACE OF DEATH

CERTIFICATE OF DEATH

E 25103
REGISTERED NO.

City of BALTIMORE: (No. University of Md. Hospital St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Bordley

(a) RESIDENCE NO. 1203 Smith St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not married

6 DATE OF BIRTH (month, day, and year): Feb 8 1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	6	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Chestertown Md.
(State or country)

PARENTS
10 NAME OF FATHER: John Bordley
11 BIRTHPLACE OF FATHER (City or town)
(State or country): Maryland
12 MAIDEN NAME OF MOTHER: Laura Brown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Maryland

14 Informant: Friend
(Address): 1127 N. Carey

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: Aug 27

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1927 to Aug 27, 1927
that I last saw he alive on Aug 27, 1927
and that death occurred, on the date stated above, at 12 o'clock p.m.

The CAUSE OF DEATH* was as follows:
Myoma uteri
Pelvic abscess
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary): Post-operative shock. Intestinal adhesions.
(duration) yrs. mos. 1 ds.

18 Where was disease contracted
if not at place of death?
Did an operation precede death? Yes Date of Aug 26, 1927
Was there an autopsy? Yes
What test confirmed diagnosis? Operation Autopsy
(Signed) [illegible], M. D.
Aug 27, 1927 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
Mt Auburn Cem	Aug 29 27
20 UNDERTAKER: Sam H. Cone Son	ADDRESS: 1731 Madison

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25104

HEALTH DEPARTMENT—CITY OF BALTIMORE

154-802

E 25104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918. S. 2nd ST., W6-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Saverio Baccala

(a) RESIDENCE NO. 918. S. 2nd ST. WARD 2C

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... NO

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Theodora Baccala

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Alberta Michael

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Baltimore Md

14 Informant Mrs Alberta Baccala

(Address) 918. S. 2nd St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1927, to Aug 28, 1927, that I last saw him alive on Aug 28, 1927, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Open Foramen Ovale

(duration) ... yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace G. Tilden, M. D.

(Address) 5N-S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem — DATE OF BURIAL: Aug 29 1927

20 UNDERTAKER: Wendell J. Ripple — ADDRESS: 310 N Eden St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25105

CERTIFICATE OF DEATH.

51 E 25105
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys B. Mitchell

(a) RESIDENCE NO. 1806 Bolton St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
WIFE of Joseph B. Mitchell

6 DATE OF BIRTH (month, day, and year) March 19 1878

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Canada

PARENTS

10 NAME OF FATHER Chas A. Broadbury

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Mary E Middleton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Canada

14 Informant Joseph B. Mitchell
(Address) 1806 Bolton St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Aug 24, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Friends Cemetery 8/29 1927

20 UNDERTAKER — ADDRESS

Chas. E. Franck 702 Madison Ave

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25106

CERTIFICATE OF DEATH.

105 V

REGISTERED NO. E 25106

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. ____ St. 2 Ward) 15-67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Rosenberg

(a) RESIDENCE NO. 2912 Ridgewood Ave St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 36 yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 60 | Months — | Days — | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): ____

(State or country): Russia

PARENTS

10 NAME OF FATHER: Aaron Abramovitch

11 BIRTHPLACE OF FATHER (city or town): ____

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Julia ____

13 BIRTHPLACE OF MOTHER (city or town): ____

(State or country): Russia

14 Informant: Isaac Rosenberg

(Address): 2912 Ridgewood Ave

15 Filed ____ 19 ____ ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

Aug 29

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1927, to Aug 29, 1927, that I last saw h er alive on Aug. 29, 1927, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary): Bronchial Asthma

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted ____

If not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) A. Vidor, M. D.

8/27, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial

Rebecca Herring Burial 8/29 19 27

20 UNDERTAKER: ADDRESS

H. Levin & Bro E Baltimore

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25107

CERTIFICATE OF DEATH.

182

E 25107
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colgate Creek St. 26 Ward)

2-FULL NAME Mrs Sexsen

(a) RESIDENCE NO. Camp Holabird St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred under mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) U S Army

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Owatonna Minn

PARENTS

10 NAME OF FATHER UK

11 BIRTHPLACE OF FATHER (city or town)

(State or country) UK

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Owatonna Minn

14 Informant Camp Holabird Md
(Address)

15 Filed....., 19..... H H [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry Inquest, autopsy or inquiry.) find that said deceased came to his death on the date stated above.

The CAUSE OF DEATH was as follows: Drowning (acc)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Signed) G B Slader M. D.
(Coroner)

Aug 29 27 (Address) 143 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul Minn Date of Burial 8/29 1927

20 UNDERTAKER Sol Kluttz Sons Bro ADDRESS 1127 E Balto St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

205 E 25108 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 25108

CERTIFICATE OF DEATH. X 117 E 25108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Ptuma

2-FULL NAME Clara Bennington

(a) RESIDENCE NO. 2124 Maryland AVE ST., WARD 21 (Non-resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Fred A Bennington

6 DATE OF BIRTH (month, day, and year) Oct 15-1888

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa -

PARENTS

10 NAME OF FATHER Charles Lyman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa -

12 MAIDEN NAME OF MOTHER Fannie Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa -

14 Informant Records -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 , 1927 , to Aug 27 , 1927 , that I last saw her alive on Aug 27 , 1927 and that death occurred, on the date stated above, at 11:15 P m.

The CAUSE OF DEATH* was as follows:

Ruptured appendiceal abscess
Generalized peritonitis.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Terminal broncho pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Raymond Wing M. D.

8/28, 1927 (Address) Johns Hopkins Hospital Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Aug 29 1927

20 UNDERTAKER William Cook — ADDRESS 502 E North

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 25109

REGISTERED NO. E 25109

DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Kutz

(a) RESIDENCE NO. 1720 Aliceann St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Kutz

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Thiem

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Henry Kutz

(Address) 1720 Aliceann St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage-Chr. Nephritis -Doabetes Mel. (Autopsy at Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Thiem (Coroner) M. D.

8/29/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. Date of Burial 8/31 1927

20 UNDERTAKER M J. Sadowski ADDRESS 705 S Linn St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25110

101-001

E 25110

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. (E. B. W. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Gough

(a) RESIDENCE NO. 1727 Ashland ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1968

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Gough

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 8-29, 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 August 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20 27, to August 27 27,

that I last saw him alive on August 27, 19 27,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Pneumococcic Meningitis

11 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Clinical

(Signed) L. E. Madden M. D.

8-28-1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Laurel Cemetery	Aug 30 1927
20 UNDERTAKER	ADDRESS
Mrs R. A. Elliott	1727 Ashland Ave

very important. See instructions on back of certificate.

8623 1927 WILSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 25111

CERTIFICATE OF DEATH

E 25111

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [illegible] St. [illegible] Ward)

BALTIMORE CITY HOSPITALS 8-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jackson

(a) RESIDENCE: NO. No [illegible] St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 187[illegible]

7 AGE 49 Years Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Jackson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Fanny

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Va

14 Informant: Saith Simpscott

(Address) 2017 Ellwyn Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

OCT 29 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-27 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-16 1927 to 8-27 1927

that I last saw him alive on 8-27 1927

and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis & Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Physical Exam

(Signed) C. Holmes Bond, M. D.

, 19 (Address)

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: Aug 29 1927

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS 1725 Ashland

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25112

CERTIFICATE OF DEATH.

182 E 25112

1-PLACE OF DEATH American Sugar Refinery Wharf,

City of BALTIMORE: (No. Foot of Woodall St. St., 5-8 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerry Jackson.(C)

(a) RESIDENCE NO. 1309 Orleans St. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 27, 1902

7 AGE	Years	Months	Days 27	IF LESS than 1 day.....hrs. or.....min.
	24	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Georgia.

PARENTS

16 NAME OF FATHER Prince Jackson.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Edith Pryor.(C)

(Address) 1309 Orleans St.

15 Filed_____ 19_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from a scow.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M. Hessenauer M. D.

(Coroner)

8/29 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashury Cemetery Date of Burial Aug 31 1927

20 UNDERTAKER Robt H Mullen ADDRESS 1515 E Eden St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25113 31 E 25113

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals St. 4-27 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Thornton

(a) RESIDENCE NO. 1141 N. Mount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	B.	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Joseph Thornton

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Alice Robinson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Hospital Records

(Address) Balto city Hosp.

15 Filed ..... 19 .....

Registrar

Per .....

AUG 29 1927

C. HAMILTON JOINES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Aug 28, 19 27

that I last saw h. alive on Aug 28, 19 27

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

Duration ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) T. E. Maddux M. D.

8/28. 1927 (Address) Balto city Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Urbanna Va	Aug 30 1927

20 UNDERTAKER Peter F. Williams ADDRESS 1515 McElderry St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 1-25114 DEATH

129 E 25114

REGISTERED NO._____

City of BALTIMORE: (No. 1517 N. Patterson Park Ave St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanora H. Scheeler

(a) RESIDENCE NO. 1517 N. Patterson Park Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Scheeler

6 DATE OF BIRTH (month, day, and year) June 21/1874

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	53	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Udba

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Sulloff

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Bernard A. Fink
(Address) 73½ Poplar Grove

15 Filed ..... 19 .....
Per .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure
(Arteriosclerosis & Probably Chr Nephritis)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Ste Kane M. D.
(Coroner)

8/29/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md Date of Burial Aug 30 1927

20 UNDERTAKER Bernard A Fink ADDRESS 73½ Poplar Grove

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25115 — E 25115

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1238 N Lombard St. 18 10 WARD)

2-FULL NAME Edgar P. Watts

(a) RESIDENCE NO. 1238 N Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara B Watts.

6 DATE OF BIRTH (month, day, and year): Sept 10. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	Years	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Oliver K. Watts.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Lottie Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Clara Watts 1238 N. Lombard St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/28 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/26 - ....., 19 27, to 8/28 .19 27.

That I last saw h alive on 8/28 .19 27.

and that death occurred, on the date stated above, at 730 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bright's disease Chronic

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Cahn M. D.

8/28 1927 (Address) 2105 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: Aug 31-27

20 UNDERTAKER: Edward A Fink ADDRESS: 734 Poplar Grove St.

AUG 29 1927

U. HAMILTON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

E 25116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112

REGISTERED NO. E 25116

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. #5 Palermo Ave St. 10 Ward)

2-FULL NAME Albert John James

(a) RESIDENCE NO. #5 Palermo Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. James

6 DATE OF BIRTH (month, day, and year): Apr 25th 1872

7 AGE — Years: 53 — Months: 4 — Days: 2 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Concrete Worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): England

PARENTS

10 NAME OF FATHER: Samuel James

11 BIRTHPLACE OF FATHER (city or town)

(State or country): England

12 MAIDEN NAME OF MOTHER: Elizabeth Watts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): England

14 Informant: Mary E. James

(Address) #5 Palermo Ave

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an (Inquest or inquiry.) thereon and from the evidence obtained (Autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) 10 hrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed Thos. B. Horton M. D.

(Coroner)

Aug 28 1927 (Address) Curtis Bay, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National — Date of Burial: Aug 30 1927

20 UNDERTAKER: John J. Fildo — ADDRESS: 200 N. Lombard

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25117

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25117

CERTIFICATE OF DEATH.

131

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) JOHNS HOPKINS HOSPITAL (St.) 2748 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Flemings

(a) RESIDENCE NO. 4410 St-Jerge ST.; WARD City

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 29 1920

7 AGE: Years 6 Months 9 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Wm Fleming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Ida Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927 to Aug 27, 1927

that I last saw h-er alive on Aug 27, 1927

and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Septicemia secondary to abscess in left thigh

Septicemia due to Staphlococcus aureus

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Multiple abscess in lung

Pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) Warfield M Foror, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL Aug 29 1927

20 UNDERTAKER Mrs J. G. Locke ADDRESS 1302 Jefferson

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25118

CERTIFICATE OF DEATH.

129 **E 25118**

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2827 Elliott St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Petrovsky

(a) RESIDENCE NO. 2827 Elliott St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Petrovsky

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years 57 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Balto

PARENTS

10 NAME OF FATHER John Petrosky

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Austria

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant: Mary Petrosky

(Address) 2827 Elliott St

15 Filed _____, 19____ Registrar

AUG 1927 C. HAMPSON JONES

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1926 to Aug 27, 1927, that I last saw h. alive on Aug 27, 1927, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Miller, M. D.

Aug 28 1927 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. Date of Burial: Aug 31 1927

20 UNDERTAKER: Frank Barnes Son ADDRESS: Woodlawn

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

5-778

E 25119

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51

E 25119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. HOPKINS HOSPITAL St. 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Miller

(a) RESIDENCE NO. 1606 N. Bradford ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md — (State or country)

PARENTS

10 NAME OF FATHER Rudolph Emily

11 BIRTHPLACE OF FATHER (city or town) Switzerland (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Louise Stanley

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country) Germany

14 Informant Records — (Address) [illegible] HOPKINS HOSPITAL

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 16 , 1927 , to Aug 28 , 1927 , that I last saw her alive on Aug 28 , 1927 and that death occurred, on the date stated above, at 3 45 9 m.

The CAUSE OF DEATH* was as follows:

Acute rheumatic fever and endocarditis.

Acute pulmonary edema.

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Raymond Wing , M. D.

, 19 (Address) Johns Hopkins Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	Aug 31 1927

20 UNDERTAKER Fred H. Lasata & Sons ADDRESS Fullerton

Spec.—1-12-23—M&T—500 Bks.

E 25120

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25120

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Marie Tuckel

(a) RESIDENCE NO. 944 S-East ST., Asylum WARD City
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 6 - 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
		3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Earl Tuckel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Minnie Pennsboro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Records -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1927, to Aug 28, 1927, that I last saw her alive on Aug 28, 1927, and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Pyelitis complicated by Enteritis

(duration) ... yrs. ... mos. 22 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? 944 S East ave

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Aug 31 1927
20 UNDERTAKER George W. Zirkler	ADDRESS 1737 E. Eager st

AUG 29 1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 25121

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25121

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5012 Palmer Ave. ST. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ida Milligan

(a) RESIDENCE No. 5012 Palmer Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert J. Milligan

6 DATE OF BIRTH (month, day, and year) Nov. 30-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	46	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Jesse Oren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Luthana Chilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Albert J. Milligan

(Address) 5012 Palmer Ave.

15 Filed Aug 29, 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1927

17

I HEREBY CERTIFY, That I attended deceased from July, 1927, to Aug 27, 1927, that I last saw h-r alive on Aug 27, 1927, and that death occurred, on the date stated above, at 10 50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Forrest Hall, M. D.

8/29 1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Aug. 30 1927

20 UNDERTAKER Horace H. Burgee — ADDRESS 3631 Falls Road

Spec.–7-17-26—A Co.—200 Bks.

Judenthal

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25122 90 **E 25122**

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

BALTIMORE CITY HOSPITALS

2-FULL NAME Catharine Judenthal

(a) RESIDENCE NO. 724 E. Monument St. Bond Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE ~~###~~ 68 Years Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Adelbert Klinick

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Josefa

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Son

(Address)

15 Filed , 19 C. PEMBERTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-23, 1927, to 8-26, 1927, that I last saw h[illegible] alive on 8-26, 1927, and that death occurred, on the date stated above, at 5 00 A. m.

The CAUSE OF DEATH* was as follows:

1 Acute myocarditis

2 Conduction defect - Heart Block

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ?

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam

(Signed) C. Holmes Bond M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary. Date of Burial: Aug 30 1927

20 UNDERTAKER: F. W. Ozarowski ADDRESS 1930 Eastern

Very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25123 46 E 25123

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 416

City of BALTIMORE: (No. Hospital for the Women of St. 2nd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarecy Blanche Brown

(a) RESIDENCE NO 1833 N Mumford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Henry Brown

6 DATE OF BIRTH (month, day, and year)
Oct 5, 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	38	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) Farnham Va

(State or country) Richmond Co, Va.

PARENTS

10 NAME OF FATHER Charles Mingo

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Richmond Co, Va.

12 MAIDEN NAME OF MOTHER Lillie Mingo

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Richmond Co. Va.

14 Informant John Henry Brown

(Address) 1833 N. Mumford ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Aug 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1927, to Aug 28, 1927,

that I last saw h[illegible] alive on Aug 28, 1927,

and that death occurred, on the date stated above, at 1:25 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of uterus with metastasis.

Symptoms 1 yr.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? 1833 N. Mumford Ave City

Did an operation precede death? Yes Date of June 23, 1927

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam. of specimen obtained at time of operation

(Signed) H. H. Kroh, M. D.

, 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Parkwood Cemetery Aug 31 1927

20 UNDERTAKER — ADDRESS

Henry Lutz 203 N. Broadway

very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

E 25124 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25124

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital St. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Stone Townsend

(a) RESIDENCE NO. Poplar Hill, Roland Park. ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred nearly Lifetime mos. — ds. How long in U. S., if of foreign birth? 68 yrs. 8 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian M. Townsend

6 DATE OF BIRTH (month, day, and year) December-20-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Manufacture
(b) General nature of industry, business, or establishment in which employed (or employer) Straw Hats
(c) Name of employer Townsend Grace Co.

9 BIRTHPLACE (city or town) ? ?
(State or country) Maryland

PARENTS

10 NAME OF FATHER Lemuel Townsend

11 BIRTHPLACE OF FATHER (city or town) ? ?
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sallie Orendorph

13 BIRTHPLACE OF MOTHER (city or town) ? ?
(State or country) Maryland

14 Informant Mr. Kenneth Townsend (SON)
(Address) Poplar Hill, Roland Park.

15 Filed 8-29, 1927 C. CHAMPION JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubular Disease
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed Smith Monroe, M. D.
(Coroner)

8/28, 1927 (Address) 3432 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL Aug-30 1927

20 UNDERTAKER Edward Monroe & Bro ADDRESS Balto.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25125

CERTIFICATE OF DEATH.

90

E 25125

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2114 Edmondson Ave. 16-69 Ward)

2-FULL NAME Amelda Harrison

(a) RESIDENCE NO. 2114 Edmondson Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Harrison

6 DATE OF BIRTH (month, day, and year): about 1870

7 AGE — Years: 57 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Wash. D.C.

(State or country)

PARENTS

10 NAME OF FATHER: Thomas Spicer

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Wash. D.C.

12 MAIDEN NAME OF MOTHER: D.K.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): D.K.

14 Informant: Ruby Rogers

(Address) 1732 Homestead

15 Filed ..... 19.....

AUG 30 1927 P.M. C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D. (Coroner)

Aug. 29, 1927 (Address) 2574 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem Date of Burial: Aug 30 1927

20 UNDERTAKER: Ehrenwerth & Son ADDRESS: 3613 Chestnut Ave

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25126

CERTIFICATE OF DEATH.

23 E 25126

1-PLACE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 2024 Penrose Ave 20-27 Ward)

2-FULL NAME Arthur William Johnson

(a) RESIDENCE NO. 2024 Penrose Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: A

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year) 7-2-15

7 AGE: Years 12 | Months 1 | Days 25 22 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Fred. C. Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Grafton Ohio

12 MAIDEN NAME OF MOTHER Mary Zanes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Elyria Ohio

14 Informant (Address) Mrs. F. C. Johnson Father

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 20th 1927, to August 27, 1927, that I last saw him alive on Aug 27, 1927, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Aortic Regurgitation (duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Pat. Lethargic encephalitis. (duration) yrs. ? mos. ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Various

(Signed) Benj. W. Curry, M. D.

8/28/27 (Address) 460 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York Pa. Date of Burial 8/30/27

20 UNDERTAKER: E. A. Farley ADDRESS Fulton Ave

Very Important. See Instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25127

CERTIFICATE OF DEATH

E 25127.

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 430 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Haselbarth

(a) RESIDENCE NO. Mercersburg, Pa., St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Unknown 1881

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER John Groce

11 BIRTHPLACE OF FATHER (City or town) Pa

(State or country)

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (city or town) Pa

(State or country)

14 Informant W. S. Dietrick

(Address) Greencastle Pa

15 Filed ..... 19 ..... Registrar

AUG 30 1927 C. HAMILTON JAMES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Aug 29th.

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 1927 to Aug 29 1927

that I last saw h[illegible] alive on Aug 29 1927

and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Esophageal stricture

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Post-operative Shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? yes Date of Aug 29th 27

Was there an autopsy? no

What test confirmed diagnosis? Operation Findings

(Signed) F. F. Lasky M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mercersburg Pa

Date of Burial 8/30/27

20 UNDERTAKER Humphreys

ADDRESS 531 W Lanvale St

very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

E 25128

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25128

CERTIFICATE OF DEATH.

17-5029

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2103 Hanover alley ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A. Collins

(a) RESIDENCE. No. 2103 Hanover alley ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Brown Collins

6 DATE OF BIRTH (month, day, and year) May 10 1964

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler and Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) House work & Chauffeur

(c) Name of employer Frederick Chas. Lemmon

9 BIRTHPLACE (city or town) (State or country) Perryman Maryland

PARENTS

10 NAME OF FATHER Rev. Henry Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Fanny Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) United Co. Maryland

14 Informant Isabel Collins Smith

(Address) 2103 Hanover alley

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27 1937

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 1936, 19..., to Aug 27, 1937, that I last saw him alive on Aug 26, 1937, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic hypertrophic cardiitis and Chronic Parenchymatous Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert L. Mitchell, M. D.

8/27, 1937 (Address) 2117 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Aberdeen Md	Aug. 30 37

20 UNDERTAKER Samuel H. Kemsley ADDRESS 578 N. Bond

Bryant

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25129

CERTIFICATE OF DEATH.

161-001

E 25129

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1102 E Monument St. 10-14 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Bryant

(Residence in Baltimore: No. 1102 E Monument St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Aug 27, 1927 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Ray Bryant

11-BIRTHPLACE OF FATHER (State or Country). N. C.

12-MAIDEN NAME OF MOTHER Fannie Weston

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie H. Bryant

(Address) 1102 E. Monument

15-

Filed. AUG 30 1927, 191.... Registrar.

1656

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 28, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia 7 days
Exhaustion

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner.)

Aug 29, 1927 (Address) 405 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL, ... 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Spec—12-23-21—E.B.R.S.—400 Bks.

E 25130 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17-24-161-801

E 25130

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. University Hospital St.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Baby Girl Carroll.

(a) Residence No...613...Dolphin St.....St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Fem'l	Black.	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 25 1927

7-AGE.	If LESS than 1 day.
.....yrs.....mos.....ds.	14 hrs. or 15 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country),

PARENTS.

10-NAME OF FATHER, Nelson Bradley

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Clara Carroll

13-BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or Country),

14-

(Informant).....

(Address).....

15-

Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 25 1927

17- I HEREBY CERTIFY, That I attended deceased from Aug 25, 1927 to Aug 25, 1927 that I last saw her alive on Aug 25, 1927, and that death occurred, on the date stated above, at 6.45 p m.

The CAUSE OF DEATH* was as follows:

Prematurity: Congenital Atelectasis

.....(Duration).....yrs.....mos. 14 hr 15 min

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?..... No

What test confirmed diagnosis? Phy Exam

(Signed) Knight Reynolds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cem'y Balto Md. DATE OF BURIAL, ..., 19....

20-UNDERTAKER ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25131
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

160 **E 25131**
REGISTERED NO.

CITY OF BALTIMORE: (No.) 14 South 11th St. (WARD) 26-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Conway

(a) RESIDENCE NO. 14 South 11th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29, 1927.

7 AGE Years Months Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Earl Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Nellie Ennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mr. Earl Conway (Address) 14 S. 11th St.

15 Filed: 30 1927, 19 Registrar RAJ

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1927, to Aug 29, 1927, that I last saw h[illegible] alive on Aug 29, 1927, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Insanitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Renal Block 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Aug 30, 1927 (Address) 330 E Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cem. DATE OF BURIAL Aug 30 1927

20 UNDERTAKER John J Coward Son ADDRESS Gorsuch

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25132

100-001

CERTIFICATE OF DEATH.

E 25132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 8-17 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Burgan

(a) RESIDENCE NO. 1921 Eutaw St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Geo C Burgan

6 DATE OF BIRTH (month, day, and year) May 3 1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Lippert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Agnes Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant George C Burgan
(Address) 1921 Ft Eutaw St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29/27 19

17 I HEREBY CERTIFY, That I attended deceased from 8/24/27, 19, to 8/29/27, 19, that I last saw her alive on 8/25/27, 19, and that death occurred, on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia and lung abscess

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) cardiac failure and pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Partial

What test confirmed diagnosis?

(Signed) H Laurence Fahnestock, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Sept 1 1927

20 UNDERTAKER: Robt G Turner Jr — ADDRESS: 1942 E Broadway

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25133

E 25133

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Declared dead at Hopkins Hospital

City of BALTIMORE: (No. 5-9 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Preston

(a) RESIDENCE NO. 1426 McElderry St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) XXXX

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Towson, Md

(State or country)

PARENTS

10 NAME OF FATHER Arthur Preston

11 BIRTHPLACE OF FATHER (city or town) Towson, Md

(State or country)

12 MAIDEN NAME OF MOTHER Amanda Jones

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Walter Darsey

(Address) Towson, Md

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Myocardial Insufficiency

(Found dead on cellar door 500 block N. Dallas St)

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) (duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

, 19 (Address) 508 Evanston

8/30/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Date of Burial Sept / 1927

20 UNDERTAKER Edward Bryan ADDRESS 691 orleans st

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 25134

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

198 E 25134

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Davenport

(a) RESIDENCE NO. 227 N. Dallas St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Robert Taylor

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Tinsler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Robert Davenport (Bro)

(Address) 227 N. Dallas St

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to stab wounds in abdomen. Homicide (Ehrl)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Fuller, M. D.

(Coroner)

8/30/27 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
asbury cemetery	aug 31 1927

20 UNDERTAKER Edward Bryan ADDRESS 1631 orleans st

Very Important. See instructions on back of Certificate.

Cor.—12-9-25—A Co.—200 Bks.

H 25135 HEALTH DEPARTMENT—CITY OF BALTIMORE

Cor.—12-9-25—A Co.—200 Bks.

E 25135

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25135

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 106 W. Rogers Ave. St. 27-55 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William S. Aumen

(a) RESIDENCE NO. 106 W. Rogers Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Annie A. Aumen

6 DATE OF BIRTH (month, day, and year) July 12th 1870

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pres. Aumen Machinery Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or Pennsylvania

(State or country)

PARENTS

10 NAME OF FATHER Francis Aumen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Rider

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna.

14 Informant Mrs. Annie A. Aumen

(Address) 106 West Rogers Ave.

15 Filed 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular Disease of Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

8/30, 19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial 9/1/27

20 UNDERTAKER Chas. B. Evans & Son ADDRESS 118 W. Mt. Royal Ave.

Very Important. See Instructions on Back of Certificate.

AUG 30 1927 HAMPSON JONES, M.D.

Spec.–7-17-26—A Co.—200 Bks.

E 25136

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25136

CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1733 Ruxton Ave. St. 15-60 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustave Rosenheim

(a) RESIDENCE NO. 1733 Ruxton Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Rosenheim

6 DATE OF BIRTH (month, day, and year) Feby. 17, 1875.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	52	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Rosenheim

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Fried

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. Leah Rosenheim. (Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28th. 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to Aug 28, 1927, that I last saw him alive on Aug 28. 1927, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows: Chronic Endocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S S Lloyd M. D.

, 19 (Address) 2232 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Hebrew Friendship Cem.	8/31/ 19 27

20 UNDERTAKER Harrid Londheim ADDRESS 118-20 W. Mt. Royal Ave.

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 25137 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 E 25137

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 7-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dallas Warwick

(a) RESIDENCE NO. Weems Va St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nancy Warwick

6 DATE OF BIRTH (month, day, and year) Nov 5/1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Raz Warwick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Esther Scofield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Nancy Warwick

(Address) Weems Va

15 Filed....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Ballou M. D.

(Coroner)

8/30/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Weems Virginia	Aug 30 1927
20 UNDERTAKER	**ADDRESS**
Indian Cook	502 E North

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25138

E 25138

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Infirmary ST., or WARD.)

2-FULL NAME Francis Asbury Harding

(a) RESIDENCE NO. 1312 N Montford Ave ST., WARD 8th

(Usual place of abode)

Length of residence in city or town where death occurred 4½ Yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine S. Schwaning

6 DATE OF BIRTH (month, day, and year) Oct 13. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
43	years	10	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Automobile Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Automobile

(c) Name of employer Mr Cook

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER J. M. S Harding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Eliza J Addison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mrs Anna Barnes

(Address) 2210 E Preston St. Baltimore, Md.

15 Filed OCT 30 1927 , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21 , 1927 , to Aug 29 , 1927 , that I last saw him alive on Aug 29 , 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

and uraemia

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Malignation of bladder

Papilloma (duration) 3 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? X

(Signed) H. Hazard Jones M. D.

, 19 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 1 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E North

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25139
1-PLACE OF DEATH

E 25139
REGISTERED NO.

City of BALTIMORE: (No. Md Genl. Hosp. St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugenia B. Watts.

(a) RESIDENCE NO. 1945 Mosher St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 1 mos. 23 ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) June 6-1906

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	21	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Morris J. Watts

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Eugenia M. Brophy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) D. C.

14 Informant Morris J. Watts

(Address) 1945 Mosher St

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or enquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or enquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Septicemia

Contributory (Secondary) (duration) Cervical Abscess yrs. mos. ds.

and (duration) yrs. mos. 1 ds.

Signed G C Bladen M. D.

Aug 30 1927 (Coroner)

(Address) 1431 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem Date of Burial Aug 31, 1927

20 UNDERTAKER: Wm J Jenkins, Sons ADDRESS: Mt Pleasant

Very important. See instructions on back of Certificate.

AUG 30 1927 G C Bladen M D

Spec.—1-12-23—M&T—500 Blks.

205-591

E 25140

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25140

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Egan

(a) RESIDENCE NO. 2101 Orleans ST., WARD City

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 29 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	29 ~~27~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Albert Egan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Anna Agatha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friends —

(Address)

15 Filed JOHNS HOPKINS HOSPITAL M. B. 30 1927, 19 RIR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 11, 1927, to Aug 28, 1927, that I last saw h[illegible] alive on Aug 28, 1927, and that death occurred, on the date stated above, at 8 30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V C Hoffman M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 31 1927
20 UNDERTAKER William Cook	ADDRESS 5025 North Ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25141
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90

E 25141
REGISTERED NO.

City of BALTIMORE: (No. 704 W. Fayette St., 4th Ward)

2-FULL NAME Petronel Skodis

(a) RESIDENCE NO. 704 W. Fayette St. Ward
(Usual place of abode)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred 25 yrs. — mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. | 4 Color or Race: W | 5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1882

7 AGE 45 Years 45 Months — Days — IF LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work No
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania
(State or country)

PARENTS

10 NAME OF FATHER Antani Vaitiuchis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER No

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Frank Skodis
(Address) 704 W Fayette St

15 Filed ___ 19 ___ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ___ yrs. ___ mos. ___ ds.

Aug 29/27 (Signed) C. E. Skodis M. D. (Coroner)

19 (Address) 143 N. Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Date of Burial: Sept 1, 1927

20 UNDERTAKER: John Gschlinnens ADDRESS: 423 S. Paca St

Very Important. See instructions on back of Certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25148 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25142

CERTIFICATE OF DEATH. + 117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 19 WARD)

2-FULL NAME Clarice Carter

(a) RESIDENCE NO. Fullerton - Md ST., WARD Bon Resident

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Ln Hosp. 2 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	S

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Joseph Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Nannie Baylis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va -

14 Informant Friends -

(Address)

15 JOHNS HOPKINS HOSPITAL

Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1927. to Aug 29, 1927. that I last saw her alive on Aug 29, 1927. and that death occurred, on the date stated above, at 2 20 A m.

The CAUSE OF DEATH* was as follows:

Appendicitis

Peritonitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/28/27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V. G. Thomas, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem DATE OF BURIAL Aug 30 1927

20 UNDERTAKER Daniel Carson ADDRESS 916 Gay ave

Spec.—1-12-23—M&T—500 Blks.

E 25143

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25143

CERTIFICATE OF DEATH.

41

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2358 McCulloh ST., 7-10 WARD)

2-FULL NAME Maud Hughes

(a) RESIDENCE NO. 2358 McCulloh ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron H. Hughes

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Fortain.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Celia Menard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Aaron H. Hughes (Address) 2358 McCulloh St

15 Filed ____ 19 Pa. ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27 1927

17 I HEREBY CERTIFY, That I attended deceased from ~~3/~~ 7/6, 1927, to 8/27, 1927, that I last saw h[illegible] alive on 8/27, 1927 and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Abscessed Varicose veins

7 yrs. Nephritis + Septicemia

(duration) yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary) Hernia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Ms

(Signed) Benj Roberts M. D.

8/29, 1927 (Address) 2139 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL Aug 30 1927

20 UNDERTAKER Daniel Easton

ADDRESS 916 Eq Ave

Spec.—1-10-21—M&T—1500 Bks.

E 25144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 25144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 242 W Bruce ST. 1427 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lloyd Collins

(a) RESIDENCE NO. 242 W Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) Jan 27, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	7 2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 107 N Monroe St. Balto.

PARENTS

10 NAME OF FATHER Charles E. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lilly Greenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lilly Collins (Address) 242 W Bruce

15 Filed AUG 30 1929 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 26, 1927, to Aug 29, 1927, that I last saw h— alive on Aug 29, 1927, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Wm S. Wright M. D.

(Address) 1209 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 31, 27

20 UNDERTAKER J Leon Hall ADDRESS 753 Druid Hill Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25145

CERTIFICATE OF DEATH.

113 . E 25145

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Kent

(a) RESIDENCE NO. 805 N. Carey St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of xxx xx

6 DATE OF BIRTH (month, day, and year) July 27/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER William Kent

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Laura Hill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md

14 Informant Wm. Kent

(Address) 530 N. Mount St

15 Filed....., 19 .....

Registrar

AUG 30 1927 HAMPSON JONES M.D.

CRL

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Aug 29/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Acute gastro-intestinal indigestion (duration) .....yrs. .....mos. .....ds.

(Signed) [signature] M. D.

(Coroner)

8/30/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Auburn Cemetery	Aug 30, 1927
20 UNDERTAKER	**ADDRESS**
Mrs. Kate R. Williams	327 N. Schroeder St

Very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 25146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 25146

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 641 W. Mulberry St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Veronica Andrews

(a) RESIDENCE NO. 641 W. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 8 mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ←→

6 DATE OF BIRTH (month, day, and year): Nov. 22, 1910

7 AGE: Years 16 Months 9 Days 7 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Morris Andrews

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Annapolis, Md.

12 MAIDEN NAME OF MOTHER: Naomi Tyson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto. Md.

14 Informant: Naomi Andrews

(Address): 641 W. Mulberry St.

15 Filed ..... 19 ..... Registrar

AUG 30 1927

RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-29-1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1927, to Aug. 29, 1927, that I last saw her alive on Aug. 29, 1927, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary): Myocarditis Pericarditis

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray, Sputum

(Signed) H. MacWilliams, M. D.

8-30-1927 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

Date of Burial: Sept 2 19

20 UNDERTAKER: Jno. H. Chase Mon

ADDRESS: 1400 Madison

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25147

E 25147

CERTIFICATE OF DEATH

198

1-PLACE OF DEATH ~~St Joseph's Hospital~~ Hospital

City of BALTIMORE: (No. ~~St Joseph's Hosp.~~ 413 St.) REGISTERED NO.

2-FULL NAME Hayward Sanford

(a) RESIDENCE NO. 1013 N. Chapel St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Sanford.

6 DATE OF BIRTH (month, day, and year) Unknown 1893

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. C.

(State or country)

PARENTS

10 NAME OF FATHER Wm. Sanford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Mrs Eva Sanford

(Address) 1013 N. Chapel

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due stab wounds involving heart & lungs. Homicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Beard M. D.

(Coroner)

8/30/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary. Date of Burial Aug 31 1927

20 UNDERTAKER Mrs R. A. Elliott ADDRESS 1725 Ashland Ave

Very Important. See instructions on back of this

Spec.—1-12-23—M&T—500 Bks.

2047 E 25148

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST., 8-17 WARD)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Bessie Munroe

(a) RESIDENCE NO. 1732 N. Dallas ST., WARD Colored

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-4-27

7 AGE: Years | Months 5 | Days 24 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md — (State or country)

PARENTS

10 NAME OF FATHER John Munroe

11 BIRTHPLACE OF FATHER (city or town) Pa — (State or country)

12 MAIDEN NAME OF MOTHER Blanche Hopkins

13 BIRTHPLACE OF MOTHER (city or town) Md — (State or country)

14 Informant Reeds — (Address)

15 JOHNS HOPKINS HOSPITAL

Filed ..... 19 ..... Registrar

AUG 30 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1927

17

I HEREBY CERTIFY, That I attended deceased from June 29 .1927. to Aug 28 .1927.

that I last saw her alive on Aug 28 .1927.

and that death occurred, on the date stated above, at 2-15 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 5 ds

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 1732 N Dallas St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashury Cemetry — DATE OF BURIAL: Aug 31 1927

20 UNDERTAKER: Mrs. P. J. Elliott — ADDRESS: 425 Ashland ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25149 | E 25149

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1107 Hillen St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew ~~Hunter~~ Francis

(a) RESIDENCE NO. 1107 Hillen St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S. If of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years 56 Months — Days — IF LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Painter

(b) General nature of industry, business, or establishment in which employed (or employer): 15

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Andrew J. Francis

11 BIRTHPLACE OF FATHER (City or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Victoria Grimwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr. Henry Fey

(Address) 313 Hamburg St. City

15 Filed ___ 19 ___ Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 19 27 to Aug 29 19 27, that I last saw h[e] alive on Aug 29 19 27, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cerebro Hemorrhage

Chronic Nephritis

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ___ yrs. 1 mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 1101 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Aug 31 19 27

20 UNDERTAKER: Henry Hoech Son — ADDRESS: 1301 E. Eager St.

very important. See instructions on back of certificate.

1927 C. HAMILTON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 25150

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25150

CERTIFICATE OF DEATH.

162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 13-54 WARD)

2-FULL NAME Billy Thomas

(a) RESIDENCE NO. 2325 Division St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1927

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
		2 2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Bernard Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Genevieve Horrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Edw. McGuire, M.D. Johns Hopkins Hospital.

15 Filed Aug 27 19 27 Par 1659 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1927

17

I HEREBY CERTIFY, That I attended deceased from 8-24, 1927, to 8-26, 1927, that I last saw him alive on 8-26, 1927, and that death occurred, on the date stated above, at 10:00 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edw McGuire, M. D.

Aug 27 19 27 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25151

86-002 E 25151

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 18-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Thomas

(a) RESIDENCE NO. 1117 W Lombard St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1927

7 AGE Years Months 3 Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Herbert Thomas

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Helen Taylor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed 19

Per 1665 Reid Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1927, to Aug 28, 1927,

that I last saw him alive on Aug 28, 1927,

and that death occurred, on the date stated above, at 2:01 A. m.

The CAUSE OF DEATH* was as follows:

Gastroenteritis

(duration) yrs. mos 20 ds

CONTRIBUTORY (Secondary) Omphalitis Marasmus

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL CJ

Date of Burial 19

20 UNDERTAKER

ADDRESS

Very important. See instructions on back of certificates.

C. HARRISON JONES M.D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25152 | CERTIFICATE OF DEATH. | 118-001 E 25152

1-PLACE OF DEATH Baltimore Md. | REGISTERED NO.

City of BALTIMORE: (No. 1213 Light St | South Balt Gen. Hospital St. | Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman cc Schneppe

(a) RESIDENCE NO. 305 Potomac Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Grace Irene

6 DATE OF BIRTH (month, day, and year): July 4, 1886

7 AGE: Years 41 | Months 1 | Days 24 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber yard

(c) Name of employer: John A Sons

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER: Bernhardt G. Schneppe

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Augusta Stork

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs. Grace Schneppe (wife)

(Address) 305 Potomac Ave

15 Filed ....., 19 ..... Registrar

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: August 28

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1927, to Aug 28, 1927, that I last saw h~~im~~ alive on Aug 28, 1927, and that death occurred, on the date stated above, at 11 40 p m.

The CAUSE OF DEATH* was as follows:

Gangrene of intestines following strangulated Hernia

(duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) .....yrs. .....mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 24 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Frederic V. D Wack, M. D.

, 19 (Address) So. Balt. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | Date of Burial Aug 31 1927

20 UNDERTAKER: John F Penny | ADDRESS 715 Light St

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 25153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST., 2-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Enrique Perez

(a) RESIDENCE NO. 57 Harrington Ave ST., Brooklyn N.Y. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 26-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
28	29	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer S Malabar

9 BIRTHPLACE (city or town) Vera Cruz
(State or country) Mexico

PARENTS

10 NAME OF FATHER Augustine Arez

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mexico

12 MAIDEN NAME OF MOTHER Anita Aguilar

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mexico

14 Informant Hospital Records
(Address)

15 Filed , 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1927

17

I HEREBY CERTIFY, That I attended deceased from August 13, 1927. to August 28. 1927.

that I last saw him alive on August 28. 1927

and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical findings + laboratory tests

(Signed) C.C. Belcher M. D.

Aug 28, 1927 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's, Hampden	Aug. 31, 1927
20 UNDERTAKER	ADDRESS
E. Leroy Stiffler	125 E. North ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25154

CERTIFICATE OF DEATH.

88-003

E 25154

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 27-41 Ward)

2-FULL NAME Frederick D. Wilson

(a) RESIDENCE NO. 15 Elerman Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec 4/1914

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	12	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Calvert Co., Md.

PARENTS

10 NAME OF FATHER JohhT. D. Wilson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Calvert Co., Md

12 MAIDEN NAME OF MOTHER Sarah M. Gott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Calvert Co., Md.

14 Informant John T. D. Wilson

(Address) 15 Elerman Ave

15 Filed_____ 19____ C. HAMPSON JONES, M. D. Registrar

1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage-Fractured Skull- Struck by automobile Parkside Drive & Hamilton Ave

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Cole M. D.

(Coroner)

8/30/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL The Parkwood Cem. Date of Burial Sept 1927

20 UNDERTAKER A. Kraul & Sons ADDRESS 38 E Fayette

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 25155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169

E 25155

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Druid Hill Park Sanitarium Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Edward Flaherty

(a) RESIDENCE NO. 827 W. Northern St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Catherine

6 DATE OF BIRTH (month, day, and year): 11-24-02

7 AGE: Years 24 Months 9 Days 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph L. Flaherty

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Catherine F. Flaherty

(Address) 827 W. N. Ave

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Drowning Suicidal

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John J. Morrissey M. D.

(Coroner)

1930. 1927 (Address) 3632 Roland ne

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Date of Burial: Aug 31. 1927

20 UNDERTAKER: H C Bowman & Son ADDRESS 517 N. Edmondson St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25156

CERTIFICATE OF DEATH.

E 25156

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hosp. St., Ward)

2-FULL NAME John G. Beegan

(a) RESIDENCE NO. 1326 Hollins St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2nd 1903

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	23	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER Joseph Beegan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Nellie McNeary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant (Address) Mrs Nellie Umberger 1326 Hollins St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stabbed through heart - Internal Hemorrhage

Right (duration) 2 hrs 20 min

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos B. Horton M. D.

(Address) Curtis Bay, Balto. Md

Aug 30 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial Aug 31st 1927

20 UNDERTAKER John F. Howard & Son ADDRESS 901 Hollins St

Very Important. See Instructions on Back of Certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25157

CERTIFICATE OF DEATH.

113

E 25157

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 704 N. Bond St St. 1-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Earle

(a) RESIDENCE NO. 704 N. Bond St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
fem le	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Dec 19/26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Thomas Earle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Dorchester Co., Md.

12 MAIDEN NAME OF MOTHER Emily Chester

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dorchester Co., Md.

14 Informant Thomas Earle

(Address) 704 N. Bond St

15 Filed ..... 19 ..... Registrar

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(Gastro-Intestinal Indigestion-Artificially fed) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. K. Collins (Coroner) M. D.

19 (Address)

8/30/27 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Laurel Cem	8-31 1927
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Madison

AUG 31 1927 [illegible] M. D.

Per

Spec.—1-12-23—M&T—500 Bks.

E 25158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 138 E 25158

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 7-9 ST., WARD)

2-FULL NAME Alice Sharpe Gage

(a) RESIDENCE NO. 55 East 86th St. N.Y. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Joseph G. Gage.

6 DATE OF BIRTH (month, day, and year) Nov. 1, 1886.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housedutries

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.Y.C.

PARENTS

10 NAME OF FATHER Robert G Sharpe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Louise Leayeraft.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) NYC.

14 Informant Joseph G. Gage (Address) 55 E. 55th St. N.Y.C.

15 JOHNS HOPKINS HOSPITAL Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1927.

17 I HEREBY CERTIFY, That I attended deceased from Aug 20th, 1927, to Aug. 30th, 1927, that I last saw her alive on Aug. 30th, 1927, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacterial exam

(Signed) Charles H. Hepburn, M. D.

19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York — DATE OF BURIAL Aug 31 1927

20 UNDERTAKER John C. Mitchell & Son — ADDRESS Howard Eutaw 1417

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25159
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

52 E 25159
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1337 Mt Royal av ST. 11-24 WARD)

2-FULL NAME Emma S Johnson.

(a) RESIDENCE NO. 1337 Mt Royal av ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., if of foreign birth? 84 yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm A Johnson

6 DATE OF BIRTH (month, day, and year): Dec 5 1843

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
83	~~25~~	~~11~~ 8	12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penn

PARENTS

10 NAME OF FATHER: John Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn

14 Informant: Samuel Johnson
(Address): 1337 Mt Royal a

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to Aug 30, 1927, that I last saw h[illegible] alive on Aug 19, 1927, and that death occurred, on the date stated above, at 2 26 a m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis

(duration) 12 yrs — mos — ds.

CONTRIBUTORY (Secondary): Senile
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Marshall Bkref M. D.

(Aug 30, 19 27) (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Sept 1 19 27

20 UNDERTAKER: Jno O Mitchell — ADDRESS: Lone 1950 Eutaw Place

Spec.—1-12-23—M&T—500 Blks.

E 25160 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99-dpl C

REGISTERED NO. E 25160

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1375 Wheatcroat ST. 15-22 WARD)

2-FULL NAME John A Sharpe

(a) RESIDENCE NO. 1375 Wheatcroat ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 4 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	86		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Morton Sharpe

(Address) [illegible]

15 Filed AUG 31 1927 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/27, 19..., to 8/27, 19...

that I last saw h alive on 8/26 - 19...

and that death occurred, on the date stated above, at 2 10 P m

The CAUSE OF DEATH* was as follows:

1a Bronchitis

1b Contusion of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj Rhett, M. D.

8/30 1927 (Address) 2133 Oak

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Aug 31/19 27

20 UNDERTAKER Wm H. Close & Son ADDRESS [illegible]

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 25161

CERTIFICATE OF DEATH

160

E 25161 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hosp 2230 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Carter.

(a) RESIDENCE NO. 7 W. York St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, ~~Married~~, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9 - 1927

7 AGE Years Months 1 Days 20 21 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto - Md

(State or country)

PARENTS

10 NAME OF FATHER Byrd, Savage

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Va

12 MAIDEN NAME OF MOTHER Martha Carter

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Balto Md

14 Informant Martha Carter

(Address) 7 W York

15 Filed ..... 19 ..... (Howard Jones M D)

AUG 31 1927 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29/27

17 I HEREBY CERTIFY, That I attended deceased from Aug 23 1927, to Aug 29 1927, that I last saw her alive on Aug 29 1927, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows: Malnutrition & Anemia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Signs

(Signed) John A. Gardner M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct — Date of Burial Aug 31 19

20 UNDERTAKER J. H. Brown's Son — ADDRESS 1519 Madison Ave

very important. See instructions on back of certificate.

Spec.—I-10-21—M&T—1500 Bks.

E 25162

HEALTH DEPARTMENT—CITY OF BALTIMORE

25162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 928 Bivans ST. 23-31 (WARD) 187

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Turner

(a) RESIDENCE NO. 928 Bivans ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., if of foreign birth? 52 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colred

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1873

7 AGE 54 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Henrietta Turner

(Address) 928 Bivans St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1927, to Aug 26, 1927, that I last saw h— alive on Aug 26, 1927, and that death occurred, on the date stated above, at 11, 1 m.

The CAUSE OF DEATH* was as follows:

Struck by automobile driven by Harrison

Auto. disclosed fracture of the Right Femur

Bilateral Lobar Pneumonia complicated

with acute dilatation of the Heart

No Operation

Otto Hardt MD

(duration) yrs. 3 mos 2 5 ds.

CONTRIBUTORY (Secondary) Chronic

(duration) yrs. 3 mos. 2 5 ds.

18 Where was disease contracted if not at place of death? Philadelphia Penn.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wounds & Compression

(Signed) Otto H. Hardt M. D.

, 19 (Address) 712 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt - Auburn — DATE OF BURIAL Aug 30 1927

20 UNDERTAKER John H Toadvine — ADDRESS 1027 Edmondson Ave

Spec.—1-10 21 M&T 1500 Bks.

E 25163

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124

E 25163

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 N Bond ST. 8-17 WARD)

2-FULL NAME Edward Sherwood Potts

(a) RESIDENCE NO. 1721 N. Bond St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Margaretta Potts

6 DATE OF BIRTH (month, day, and year) May 4-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
43		3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Transfer Business

(b) General nature of industry, business, or establishment in which employed (or employer) General Trucking

(c) Name of employer Edw S Potts & Brother

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry A Potts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sally L Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Frances M Potts

(Address) 1726 N Bond St

15 Filed AUG 1 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1927

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1927, to Aug 28, 1927, that I last saw him alive on Aug 27, 1927, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 5 mos 22 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical. Virginia Phthalein test.

(Signed) George A Bender M. D.

8/29, 1927 (Address) 1517 E 20th Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Park Ward — DATE OF BURIAL Aug 31 1927

20 UNDERTAKER Josiah Syfer — ADDRESS 1600 North Ave

Cor.—12-9-25—A Co.—200 Bks.

Herman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25164

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

170 E 25164

REGISTERED NO.

City of BALTIMORE: (No. Md. Gen. Hosp. St. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathan Herman

(a) RESIDENCE NO. 2 E Preston St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of: Mamie Herman

6 DATE OF BIRTH (month, day, and year): 1896

7 AGE: Years 31 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

10 NAME OF FATHER: Balt md

11 BIRTHPLACE OF FATHER (city or town): Jacob Herman

(State or country)

12 MAIDEN NAME OF MOTHER: Esther Hanna

13 BIRTHPLACE OF MOTHER (City or town): Russia

(State or country)

PARENTS

14 Informant: Jacob Herman

(Address): 1877 Emory St

15 Filed..... 19.....

Registrar

Very Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/31 19 27

17 I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gunshot wound in chest

(duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Thomas M. D.

(Coroner)

19 27 (Address) 20 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Herron Southern Cr Date of Burial 8/31 19 27

20 UNDERTAKER: Jack Levis ADDRESS 1439 E Balt

1927 HAMILTON JONES M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25165

CERTIFICATE OF DEATH.

E 25165

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No.

1-PLACE OF DEATH

City of BALTIMORE: (No. On way to Mercy Hosp. 4-30 St., Ward)

2-FULL NAME Daniel F. Mc. Adams

(a) RESIDENCE NO. 1724 Irving St. N.E. Washington D.C. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. / ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 26 1870

7 AGE: Years 57 Months 5 Days 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): farmer

(c) Name of employer

9 BIRTHPLACE (city or town): Mass

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: A. Mc. Adams

(Address) 1724 Irving St. N.W. Washington

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. disease heart

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Duration ..... yrs. ..... mos. ..... ds.

Signed M. F. Riley M. D.

(Coroner)

Aug 29, 1927 (Address) 1659 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death... yrs.. mos.. ds. In the State... yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Somerville Mass Date of Burial: Aug 31 1927

20 UNDERTAKER: Harry W. Ellen ADDRESS 1944 W. North Ave

VERY IMPORTANT. See INSTRUCTIONS ON BACK OF

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25166

CERTIFICATE OF DEATH.

90 E 25166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 Stockton, St. 15-59 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Weeks,

(Residence in Baltimore: No. 2316 Stockton St.; 48 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH, (Month) Aug (Day) 8, (Year) 1879

7-AGE, 48 yrs. 21 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E Douglass

(Address) 717 Cumberland St

15- Filed AUG 31 1927, 191 C. HAMPTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Aug (Day) 29, (Year) 1927

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1927, to Aug 29 1927, that I saw h-e alive on 8-28-1927, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Cardiac

(Duration) yrs. 2 mos. ds.

(Signed) W. R. Hopkins M. D.

191... (Address) 618 Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, Aug 31 1927

20-UNDERTAKER Virginia A Brooks ADDRESS 1023 N. Carey St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25167

CERTIFICATE OF DEATH.

E 25167

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 149 Enon alley Ward)

2-FULL NAME Benjiman Temple

(a) RESIDENCE NO. 149 Enon alley St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannie Temple

6 DATE OF BIRTH (month, day and year): about 1863

7 AGE: Years 64 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER: Isaac Temple

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER: Dorothy Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address) Hannie Temple 149 Enon alley.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Aug. 31, 1927 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Aug 31 1927

20 UNDERTAKER: Dan'l Easton ADDRESS 416 Park

Very Important. See Instructions on back of Certificate.

4pec.—1-12 23—M&T—500 Blks.

905-643

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25168
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

+ 113

E 25168
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 79 WARD)

2-FULL NAME Betty Burns

(a) RESIDENCE NO. Texas - Md ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-14-27

7 AGE: Years | Months 1 2 mos | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS
10 NAME OF FATHER Leonard Burns
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —
12 MAIDEN NAME OF MOTHER Rita Parks
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Friends
(Address) Johns Hopkins Hospital

15 Filed AUG 31 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 13 1927 to Aug 30 1927
that I last saw her alive on Aug 30 1927
and that death occurred, on the date stated above, at 10 20 a. m.
The CAUSE OF DEATH* was as follows:
Acute Gastro-Intestinal Indigestion.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? —

(Signed) Lyman Wells M. D.
8/31 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mays Chapple Relto. | DATE OF BURIAL: Sept 1 1927

20 UNDERTAKER: Wm C Brooks. | ADDRESS: Sparks Md

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25169

CERTIFICATE OF DEATH.

135

E 25169

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 15-60 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lowenwall

(a) RESIDENCE NO. ~~Same~~ 1706 Moreland St. Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — dr.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pesha Bella

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Caspar Lowenwall

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Wm Lowenwall

(Address) 1706 Moreland ave

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1927, to Aug 30, 1927, that I last saw him alive on Aug 30, 1927, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Adenoma of Prostate

(duration) yrs. 2 mos. 18 ds.

CONTRIBUTORY (Secondary) Uremia & Myocardial failure

(duration) yrs. mos. 11 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J. Blackman, M. D.

8-30, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Ft Lincoln Southern Ave 8/31 1927

20 UNDERTAKER ADDRESS

Sol Levinson & Bro Eutaw St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25170

CERTIFICATE OF DEATH.

E 25170
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Le Gate Ave St. 26 Ward) 7-36

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Anderson

(a) RESIDENCE NO. Camp Holabird St. Ward San Rec. (Pa)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred \ yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. 6 mos. \ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6 1899

7 AGE — Years: 27 — Months: 11 — Days: 23 — If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Soldier
(b) General nature of industry, business, or establishment in which employed (or employer): U.S. Army
(c) Name of employer

9 BIRTHPLACE (city or town) Eddystone
(State or country) Pa

PARENTS

10 NAME OF FATHER N K

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N K

12 MAIDEN NAME OF MOTHER N K

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N K

14 Informant Regents
(Address) Camp Holabird

15 Filed....., 19.....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acc Drowning

(duration) Instan yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Signed: C. Gates M. D.
(Coroner)

8/31, 19 27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — Date of Burial: 8/31 1927

20 UNDERTAKER: Sol Kluesner & Bro — ADDRESS: 112 E Baltimore St

Spec.—1-12-23—M&T—500 Bks.

E 25171 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25171

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4111 Kathland ave ST. 45-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Roband Tyus Pair Fleet

(a) RESIDENCE NO. 4111 Kathland ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Washington T. Fleet

6 DATE OF BIRTH (month, day, and year) Jan 3rd 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
74	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Alexandria Va

PARENTS

10 NAME OF FATHER Wm Thos Baird

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Ophelia Cawthorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co. Va

14 Informant Richard Tyus Fleet (Address) 4111 Kathland ave

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 . 1927 . to Aug 29 . 1927 . that I last saw her alive on Aug 29 . 19.. and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 2 mos 4 ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Jno Conrad Bode M. D.

19 (Address) 1900 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Sept 1st 1927

20 UNDERTAKER Geo. Huber & Son — ADDRESS 2503 Ed. ave.

Cor.—12-9-25—A Co.—200 Bks.

E 25172

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25172

CERTIFICATE OF DEATH.

202

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. New Hospital St. 27-44 Ward)

2-FULL NAME Harry E. Collins

(a) RESIDENCE NO. 2908 Overland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Mary T. Collins

6 DATE OF BIRTH (month, day, and year) October 10 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis Md

(State or country)

PARENTS

10 NAME OF FATHER George Collins

11 BIRTHPLACE OF FATHER (city or town) England

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Lee

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant Mrs Mary T. Collins

(Address) 2908 Overland Ave

15 Filed ..... 19 ..... Registrar

AUG 31 1927 C. HUNTER JONES, M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and hour) Aug 29 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry)

thereon, and the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) I find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of Peduncle of Cerebellum

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (secondary) Shock

(duration) yrs. mos. ds.

Aug 29/27 Signed G. C. Yates (Coroner) M. D.

19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery Date of Burial Sept. 1st 1927

20 UNDERTAKER Henry Hoech Son ADDRESS 1301 E. Eager St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25173

CERTIFICATE OF DEATH

49 E 25173

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1828 N Dallas Street St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Wilson Thomas

(a) RESIDENCE NO. 1828 N. Dallas Street. St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 57 yrs. 7 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Thomas

6 DATE OF BIRTH (month, day, and year) January-3-1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	57	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) Printing

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) Cambridge

(State or country) Maryland

PARENTS

10 NAME OF FATHER John E. Thomas

11 BIRTHPLACE OF FATHER (City or town) Cambridge

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Wilson

13 BIRTHPLACE OF MOTHER (city or town) Cambridge

(State or country) Maryland

14 Informant Mrs. Mabel Thomas (wife)

(Address) 1828 N. Dallas Street. City

15 Filed ..., 19 ... Registrar

AUG 31 1927 C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 19 27, to Aug 29, 19 27,

that I last saw h wife alive on Aug 25, 19 27,

and that death occurred, on the date stated above, at 10 07 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopy

(Signed) Estella Cantor, M. D.

8/29. 19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Western Cemetery	19
20 UNDERTAKER	ADDRESS
STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	

very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25174

CERTIFICATE OF DEATH

31

E 25174

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3407 Lyndale ave St., 16-40 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Handy

(a) RESIDENCE NO. 3407 Lyndale Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ late Chas. E. Handy

6 DATE OF BIRTH (month, day, and year) June 11/85

7 AGE — Years: 42 Months: 2 Days: 17 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstres

(b) General nature of industry, business, or establishment in which employed (or employer): 069

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER Geo. Nelson

11 BIRTHPLACE OF FATHER (City or town): N. Y.

(State or country)

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Mrs. Harry Kunster

(Address) 3407 Lyndale Ave

15 Filed ....., 19 .....

Registrar

NAA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 29/27 19

17 I HEREBY CERTIFY, That I attended deceased from August 27 1927 to August 29 1927

that I last saw h.. alive on August 29 1927

and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Aug 29 1927 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: 8/1/27

20 UNDERTAKER: Hardy Herring — ADDRESS 2016 Orleans St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 25175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

E 25175

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1319 E Monument St. 5-8 Ward)

2-FULL NAME Stella ~~Brooks~~ Williams

(a) RESIDENCE NO. 1319 E Monument St. IX Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28 97

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Isaac Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) St Thomas Virgin Islands

12 MAIDEN NAME OF MOTHER Elizabeth Bowles

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) St Thomas V I

14 Informant Isaac Williams

(Address) 1319 E Monument

15 Filed ..... 19 .....

1666 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Congenital Heart

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) H H Sallin M. D.

(Coroner)

8/30/27 (Address) 505 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

HOPKINS HOSPITAL C HAMPSON JONES M D

SEP 1 1927

Spec.—12-9-25—A Co.—200 Bks.

E 25176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 25176

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hospls

City of BALTIMORE: (No. Balto Md St., 5-8 Ward)

2-FULL NAME Harriet Irma Taylor

(a) RESIDENCE NO. 118 Colvin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Taylor

6 DATE OF BIRTH (month, day, and year):

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: (

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant: Balto City Hospls

(Address) Balto Md

15 Filed C. HAMPTON JONES, M. D. 1927 Registrar

1927 Reg. 1660

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-28-27

17

I HEREBY CERTIFY, That I attended deceased from 7-22- 19 27 to 8-28- 19 27, that I last saw h[illegible] alive on 8-28 19 27, and that death occurred, on the date stated above, at 9.10 p. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

Mitral stenosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis with cardiac neurosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical findings

(Signed) Charles Pearlstein, M. D.

8/13. 1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

E 25177

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25177

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hospitals

City of BALTIMORE: (No. Balto Md St. 26-27 Ward)

2-FULL NAME Henry A. Baker

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
62				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospts

(Address) Balto Md.

15 Filed 19 Registrar

1670 AP H

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-28-27

17

I HEREBY CERTIFY, That I attended deceased from 6-20-, 1927, to 8-28, 1927, that I last saw h.. alive on 8-28, 1927, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Senile Psychosis, Agitated Depression

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Philip Pearlstein, M. D.

8/29 1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND

Spec.—1-12-23—M&T—500 Bks.

E 25178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25178

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 Eastern Ave. WARD) 2-4

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Brown.

(a) RESIDENCE NO. 1425 Eastern Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mall.

4 COLOR OR RACE: Colored Black.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1877.

7 AGE: Years 50. Months — Days — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... unknown

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Profit Va.

PARENTS

10 NAME OF FATHER Ned. Brown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Profit Va

12 MAIDEN NAME OF MOTHER Mrs Coale.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Profit Va.

14 Informant Mrs. Lillie Holland

(Address) 1422 Easton Ave.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

1c DATE OF DEATH (month, day, and year) August 27 1927

17

I HEREBY CERTIFY, That I attended deceased from August 11, 1927, to August 24, 1927, that I last saw him alive on August 23, 1927 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) Samuel Silverstein, M. D.

, 19 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Profit Va — DATE OF BURIAL: Aug 31 1927.

20 UNDERTAKER: Wendell Hopper — ADDRESS 300 N. Edmondson

1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 25179 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25179

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolores Janaskie

(a) RESIDENCE NO. 241 S Washington St WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1926

7 AGE Years Months Days If LESS than 1 day, hrs. or..... min.

11 mo. 2

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Janaskie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Agnes Buzzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1927, 19 ORH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1927, to Aug 30, 1927, that I last saw h-s alive on Aug 30, 19-, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alexander J Schaffer, M. D.

, 19 (Address) The Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem DATE OF BURIAL Sept 1 1927

20 UNDERTAKER John M Weber 1813 ADDRESS Bank 30

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 25180

CERTIFICATE OF DEATH.

57 · E 25180

REGISTERED NO._____

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No. Wilkens Ave extended St. 76-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Rayness

(a) RESIDENCE NO. 3401 Hudson St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emanuel Rayness

6 DATE OF BIRTH (month, day, and year): April 4-1875

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	52	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~ 37

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town): Poland

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Unknown

11 BIRTHPLACE OF FATHER (city or town): "

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): "

(State or country): Poland

14 Informant: Emanuel Rayness

(Address): 3401 Hudson St

15 Filed..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-30 1927

17

I HEREBY CERTIFY, That I attended deceased from 8-26, 1927, to 8-30, 1927, that I last saw her alive on 8-30, 1927, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency—

Diffuse Chronic Nephritis and Cystitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests

(Signed) C J Knapp, M. D.

8-30, 1927. (Address) Saint Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Stanislaus Sept 3 Date of Burial 1927

20 UNDERTAKER: John N Wilder ADDRESS: 1803 Bank St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25181

CERTIFICATE OF DEATH.

E 25181

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. St. Ward)

2-FULL NAME John R. Berkstresser

(a) RESIDENCE NO. 1805 Barclay St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace B. Berkstresser

6 DATE OF BIRTH (month, day, and year): Aug 13, 1887

7 AGE: Years 40; Months; Days 17; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Hauling Co

(c) Name of employer: Self.

9 BIRTHPLACE (city or town): York, Pa.

(State or country)

PARENTS

10 NAME OF FATHER: [illegible] Berkstresser

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pa.

12 MAIDEN NAME OF MOTHER: Clara Cox

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Pa.

14 Informant: Grace B. Berkstresser

(Address) 1805 Barclay St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart.

(duration) ..... yrs. ..... mos. 1 hr ds.

CONTRIBUTORY (Secondary) Acute Gastro-Enteritis

(duration) ..... yrs. ..... mos. 12 hrs ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Aug 31 1927 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York, Pa.

Date of Burial: 9/1 1927

20 UNDERTAKER: Horace H. Burgee

ADDRESS: 3631 Hillen Road

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25182 E 25182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4232 Falls Road ST. 27-24-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Abbott

(a) RESIDENCE NO. 4232 Falls Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March-2-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Francis Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nellie Tuckner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Emma F. Abbott

(Address) 4232 Falls Road

15 Filed 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1927

17

I HEREBY CERTIFY, That I attended deceased from June, 1912, to Aug 30, 1927, that I last saw h.er alive on Aug 29, 1927, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) X yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Elmer Hoffman, M. D.

8/31, 1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Marys (Lambden)	Sept 1- 1927

20 UNDERTAKER Grace H. Burgee ADDRESS 3431 Falls Rd

THOMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 25183 HEALTH DEPARTMENT—CITY OF BALTIMORE 184 E 25183

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 N. High St 5-6 ST. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ephraim Zelie Silver

(a) RESIDENCE NO. DURHAM N.C ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Silver

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Silver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dunkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Annie Silver
(Address) Durham St. C

15 Filed . . . . , 19 RKB Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 19 27

17 I HEREBY CERTIFY, That I attended deceased from 8-27 , 19 27, to 8/30 , 19 27, that I last saw h live on 8/30 , 19 27, and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

duration Indefinite mos. ds.

CONTRIBUTORY (Secondary) Per Carditis

(duration) abt 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Durham, No C

Did an operation precede death? NV Date of

Was there an autopsy? NV

What tests confirm diagnosis? Signs & symptoms

(Signed) W. H. Chilcoat M. D.

, 19 (Address) 2005 Pendena

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Durham St C — DATE OF BURIAL 8/31/1927

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balt

1927 C. HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 25184 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 451 E. 23rd Street

CITY OF BALTIMORE: (No.) ST. 12-50 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Stewart

(a) RESIDENCE No. 451 E. 23rd St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1y yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 8/27/27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	3½	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Alex. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mamie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Alex. Stewart (Address) 451 E. 23rd St.

15 Filed , 19 Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-30-27

17 I HEREBY CERTIFY, That I attended deceased from 8-27- , 1927 , to 8-30 , 1927 , that I last saw h— alive on 8-29 , 1927 , and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) M. B. Butler , M. D.

, 19 (Address) 420 N. Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL 9/1/27

20 UNDERTAKER George J. Reilly ADDRESS 1735 Hanford

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25185

CERTIFICATE OF DEATH.

185 E 25185

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C. Rowan

(a) RESIDENCE NO. 1020 E Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Apl. [illegible]

7 AGE: Years 70 Months about Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) U S A

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Hospital Records

(Address) Mercy Hospital

15 Filed....., 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. femur left. Hemorrhage

11 days (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

Aug. 31, 1927 (Signed) H. T. Finley (Coroner) M. D.

(Address) 1639 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 1020 E Lombard

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross (Brooklyn) Date of Burial 8-1-27

20 UNDERTAKER: Geo. C. Farley ADDRESS 1800 W Fayette

Spec.–7-17-26—A Co.—200 Bks.

E 25186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 25186

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 25-75 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Schneider

(a) RESIDENCE NO. 205 S. 6th St. Ward Baltimore Md.

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Schneider

6 DATE OF BIRTH (month, day, and year) Oct 13th 1851

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	75	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Philip Schneider

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth S

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records

15 Filed JUL 1 1927, 19 R. Key Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 22 19 27, to June 28 19 27,

that I last saw h alive on June 28 19 27,

and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic - acute

arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Course

(Signed) C. Hampson Jones M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial 6-1st 19 27

20 UNDERTAKER E. T. B. Harle ADDRESS 115 E. 23rd St.

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25187

CERTIFICATE OF DEATH.

185 E 25187

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Strecker

(a) RESIDENCE NO. 421 South way ST. St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White Am.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Mr Harry Strecker

6 DATE OF BIRTH (month, day, and year): 14 - Dec 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D C

PARENTS

10 NAME OF FATHER: John L Lindsay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: C Ranenguch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs L Strecker (Address) Church Home Infirmary

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30 1927

17

I HEREBY CERTIFY, That I attended deceased from June 25, 1927, to Aug 30, 1927,

that I last saw her alive on Aug 30, 1927

and that death occurred, on the date stated above, at 3.10 P.m.

The CAUSE OF DEATH* was as follows:

Hemolytic Strep Septicaemia

(duration) mos 5 ds.

CONTRIBUTORY (Secondary) Fracture of Neck of Femur and Lacerations.

Accidental Fall on Step on Pavement (duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 28th

Was there an autopsy? No.

What test confirmed diagnosis? None allowed.

(Signed) A Krauss Rothdale M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Linden Park — DATE OF BURIAL: Sept 2 1927

20 UNDERTAKER: Jarrett Eyler — ADDRESS: 1600 W North Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25188

CERTIFICATE OF DEATH.

27-44 90

E 25188

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 5 Ailsa Ave St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth N. Redman

(a) RESIDENCE NO. 5 Ailsa Ave St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John C. Redman

6 DATE OF BIRTH (month, day, and year) March 10/1867

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At home

9 BIRTHPLACE (city or town) ____

(State or country) Dorchester Co., Md

PARENTS

10 NAME OF FATHER Isaac Taylor

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Elizabeth Travers

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Dorchester Co., Md

14 Informant John C. Redman

(Address) 5 Ailsa Ave

15 Filed ____, 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Aug 30/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h___ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency - Probably Endocarditis

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) History of Teeth infection (Rheumatism?) (duration) ___ yrs. ___ mos. ___ ds.

(Signed) ____, M. D.

(Coroner)

9/1/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Date of Burial Sept 2 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25189

CERTIFICATE OF DEATH.

E 25189

1 PLACE OF DEATH

CITY OF BALTIMORE. No. 605 Brook Ave ST. near Overlea. WARD 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace M Billinger

(a) RESIDENCE NO. 605 Brook Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, (or) WIFE of Stephen Billinger

6 DATE OF BIRTH (month, day, and year) Sept 22 1876

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
50	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Jos. Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Redmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Stephen Billinger (Address) 605 Brook Ave

15 Filed 1927 .19.. E. LIVINGSTONE, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 15th 1924 to Aug 31 1927.

that I last saw he alive on Aug 30 1927.

and that death occurred, on the date stated above, at 10 20/4 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) Hypertension + Hemiplegia (duration) 4 yrs. mos ds.

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs + Symptoms

(Signed) Edw H Benston M. D.

8/31 1927 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Sept 3 1927

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Gall Rd.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25190 E 25190

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E. Baltimore St. WARD) 10

REGISTERED NO. 905

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Weinberg

(a) RESIDENCE No. 2100 E Baltimore St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jack Weinberg

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 89 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: old age

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: A. Smith Gall

(Address) 7313 Windsor Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/27

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible], to Aug 31, 19[illegible], that I last saw h[illegible] alive on Aug 31, 19[illegible], and that death occurred, on the date stated above, at 5:30 — 9 m.

The CAUSE OF DEATH* was as follows:

~~Arteriosclerosis~~

Myocardial insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ~~Arteriosclerosis~~

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) 1810 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nelson Southern Ave

DATE OF BURIAL: 9/1 19 27

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Baltimore St

HAROLD R. JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

Krock

E 25191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25191

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST. 10-14 WARD)

2-FULL NAME Mary Aquilina Krack

(a) RESIDENCE NO. Aiguith Street ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June-29-1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Krack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Lauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sister Mary Dionysia
(Address) Notre Dame, Aiguith St. City

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August-30-1927

17 I HEREBY CERTIFY, That I attended deceased from Aug-4- , 1927 , to Aug-30- , 1927 , that I last saw her alive on Aug-30- , 1927 , and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Evidence

(Signed) Jno. B. Sybert, M. D.

, 19 (Address) 2802 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Med DATE OF BURIAL Sept 2 1927

20 UNDERTAKER Frank A. Fink ADDRESS 810 N. Eutaw

P. 1-1927 C. HAMPSON JONES, M.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25192

CERTIFICATE OF DEATH

E 25192

REGISTERED NO. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (T.B.) St., 3rd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Shalton

(a) RESIDENCE NO. 118 S. Caroline st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE Years 32 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jerry Mondowmey

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Armstrong

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1927, to August 30, 1927,

that I last saw her alive on August 30, 1927,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

one month (duration)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) S. E. Maddux M. D.

8-31-27, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Cathay Cemetery Sept 2, 1927

20 UNDERTAKER ADDRESS

Wm. P. C. Elliott 2258 Eutaw Pl

C. HAMILTON JONES, M. D.

SEP 1 1927

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25193

CERTIFICATE OF DEATH.

E 25193

REGISTERED NO. 16-2257

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 N. Calhoun ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Turner

(a) RESIDENCE No. 1126 N. Calhoun ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Turner

6 DATE OF BIRTH (month, day, and year): Unknown 1863

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Charles Co. Md.

PARENTS

10 NAME OF FATHER: Cenithany Taye

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): John Turner 1126 Calhoun st

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 29 1927

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1927, to Aug 29, 1927, that I last saw her alive on Aug 29, 1927 and that death occurred, on the date stated above, at 12 15 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitis and Genital Nephritis

(duration) — yrs. 3 mos ? ds.

CONTRIBUTORY (Secondary) Diabetis & nephritis

& Age (duration) — ?yrs.? mos.? ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. D. Hall, M. D.

, 19 (Address) 426 E 23rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary

DATE OF BURIAL: Sept 1, 1927

20 UNDERTAKER: Mrs. R. G. Elliott

ADDRESS: 1325 Ashland Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25194 E 25194

CERTIFICATE OF DEATH.

REGISTERED NO. 2331

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Hanselman Ct. ST. WARD)

2-FULL NAME Ada Bolar Grimes -

(a) RESIDENCE NO. 1118 Hanselman Ct. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Grimes. -

6 DATE OF BIRTH (month, day, and year) Oct. 31 - 1896

7 AGE	Years	Months	Days	If LESS than 1 day hrs or min.
	30	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework -

(b) General nature of industry, business, or establishment in which employed (or employer) Private Home. -

(c) Name of employer Mrs. M. Selma. -

9 BIRTHPLACE (city or town) (State or country) Fairfield, Md.

PARENTS

10 NAME OF FATHER Frank Bolar

11 BIRTHPLACE OF FATHER (city or town) Orange Co. (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D.C. -

14 Informant Mother (Mary Jackson Arrington) (Address) 1118 Hanselman Ct.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 - 31 1927

17

I HEREBY CERTIFY, That I attended deceased from 4 - 27, 1927, to 8 - 31, 1927, that I last saw her alive on 8 - 31, 1927, and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus

following Childbirth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Hovey M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Ct	Sept 3 1927
20 UNDERTAKER	ADDRESS
S. E. Brown's Son	W. Balto

Spec.—1-12-23—M&T—500 Bks.

205522

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25195

CERTIFICATE OF DEATH.

32 E 25195

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1927 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garland Lynch

(a) RESIDENCE NO. 532 Robins Alley ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 20, 1922

7 AGE: Years 5 | Months — | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ___ ___, 19 ___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1927, to Aug. 30, 1927, that I last saw h alive on Aug. 30, 1927, and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Meningitis (Tuberculous)

(duration) — yrs. mos 20 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? Yes practically

What test confirmed diagnosis? Lumbar Puncture

(Signed) H. Rothman, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — DATE OF BURIAL: Sept 2 1927

20 UNDERTAKER: Joseph A Lucky — ADDRESS: 48[illegible] Pennsylvania Avenue

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25196

CERTIFICATE OF DEATH

31 E 25196

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hosp - St. 11-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robertson Thomas

(a) RESIDENCE NO. 723 W Lanvaga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (Write the word)
male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town) unknown

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Mary Robinson

(Address) 723 W. Saratoga St

15 Filed ..... 19 .....

Registrar

SEP 1 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-29-27

17 I HEREBY CERTIFY, That I attended deceased from 8-16-27, 19.., to 8-29-27, 19..,

that I last saw him alive on 8-29-27, 19..,

and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Repeated hemoptysis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted unknown

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Teague, M. D.

. 19 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

Date of Burial Sept 1 19 27

20 UNDERTAKER Leonard Whalen

ADDRESS 309 Myrtle Ave.

Spec.—1-12-23—M&T—500 Blks.

E 25197

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 25197

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 627 Wyeth ST. 21-29 WARD)

2-FULL NAME August Gotth

(a) RESIDENCE NO. 627 Wyeth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

6a If married, widowed, or divorced (or) WIFE of: Mary A Gotth

6 DATE OF BIRTH (month, day, and year): June 1876

7 AGE: Years 51 Months 7 Days 29. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sales

(b) General nature of industry, business, or establishment in which employed (or employer): Worker

(c) Name of employer: Mills Safe Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Gotth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary E Wirth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mary A Gotth (Address) 627 Wyeth St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1927 to Aug 30, 1927 that I last saw ~~him~~ alive on Aug 31, 1927 and that death occurred, on the date stated above, at 5:50 a m.

The CAUSE OF DEATH* was as follows:

Pul. T.B.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Chem

(Signed) John G Schwarzmeier M.D.

Aug 30 1927 (Address) 11 New Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westen Cem DATE OF BURIAL Sept 2 1927

20 UNDERTAKER: Wm Cain & Co ADDRESS 502 E North Ave

Spec.—1-12-23—M&T—500 Bks.

E 25198

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25198

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2536 E. Monument ST., 1-12 WARD)

2-FULL NAME Frederick L Hammerbacher

(a) RESIDENCE No. 2538 E Monument ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Hammerbacher

6b DATE OF BIRTH (month, day, and year): May 21, 1860

7 AGE — Years: 67 | Months: 3 | Days: 10 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Geo Hammerbacher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Annie Hammerbacher
(Address) 2538 E Monument St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1927, to Aug 31, 1927, that I last saw h[illegible] alive on Aug. 30, 1927, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Stomach)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis Krause, M. D.

, 19 ..... (Address) 202 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Sept 3 1927

20 UNDERTAKER: H. Cook — ADDRESS: 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25199

CERTIFICATE OF DEATH.

38 E 25199

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Gol of America Hosp

CITY OF BALTIMORE: (No. 418 W. Lexington ST. 10-14 WARD)

2-FULL NAME Martin A Bittere

(a) RESIDENCE NO. 925 Hartford Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9. 1868

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Highway Dept

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John S Bittes

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Hester A Farr

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mary A. Bruff
(Address) 1001 Franklin Ave.

15 Filed SEP 1 1927 19 R. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1st. 1927. to Aug 30th. 1927.

that I last saw him alive on Aug 30th. 1927.

and that death occurred, on the date stated above, at 8:10 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Syphilis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jaroslav Hulla, M. D.

19 (Address) 2214 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon

DATE OF BURIAL Sept 2 1927

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.–7-17-26—A Co.—200 Bks.

25200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

112 ✓

REGISTERED NO. E 25200

1-PLACE OF DEATH

City of BALTIMORE: (No. 606 N. Bethel St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Thomas

(a) RESIDENCE NO. 606 N. Bethel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. - 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	68	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Mary Watkins
(Address) 606 N. Bethel

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
aug - 30 - '27

17 I HEREBY CERTIFY, That I attended deceased from aug 30, 19 27, to aug 30, 19 27
that I last saw her alive on aug 30 (A.M.), 19 27
and that death occurred, on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Acute Indigestion

(duration) ..... yrs. ..... mos. ½ ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Medical Test
(Signed) Jas. H. Walters, M. D.
, 19 (Address) 1635 McElderry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Zion	Sept 1 1927
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

Very Important. See instructions on back of certificate.

C. H. HAMILTON JONES, M. D.

SEP 1 - 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25201

CERTIFICATE OF DEATH.

113 V

REGISTERED E 25201

1-PLACE OF DEATH

City of BALTIMORE: (No. 1308 N. Stricker St., 16 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Gross

(a) RESIDENCE NO. 1308 N. Stricker St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22, 1927.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Gross.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Regina Cheek

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Regina Gross

(Address) 1308 N. Stricker St.

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia - Colitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no other disease

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo T. Hennessy M. D.
(Coroner)

Aug 31 19 27 (Address) 2577 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.. ..... mos.. ..... ds. In the State..... yrs.. ..... mos.. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery — Date of Burial Sept 1 1927

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Presstman St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25202

CERTIFICATE OF DEATH.

171 L 25202

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. U. S. Marine Hospital St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Mc Intosh.

(a) RESIDENCE NO. 1644 Thames St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5, 1902

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	25	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer S. S. Irene

9 BIRTHPLACE (city or town)

(State or country) Scotland

PARENTS

10 NAME OF FATHER James Mc Intosh

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret Martin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ingrowed Bowels Right Wrist
from Th Fatal Hemorrhage
(Suicide)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

9/1, 1927 (Address) 722 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Mary's, Hampden — Sept. 1, 1927

20 UNDERTAKER E. Leroy Stiffler — ADDRESS 125 E. North Ave.

SEP 1 - 1927 HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25203
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

40 E 25203
REGISTERED NO.

CITY OF BALTIMORE: (No. 1810 N Broadway ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane A Kreuner

(a) RESIDENCE NO. 1810 N Broadway ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): W.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Kreuner

6 DATE OF BIRTH (month, day, and year): Feb 14 58

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John A Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Boyd.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Jennie R Blake
(Address) 2408 Madison ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31 1927

17 I HEREBY CERTIFY, That I attended deceased from July 2 , 1927 , to Aug 31 , 1927 ,
that I last saw her alive on Aug 30 , 1927
and that death occurred, on the date stated above, at 2 30 a m.
The CAUSE OF DEATH* was as follows:

Vascular Heart Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

(Address) 1107 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery Baltimore Md

DATE OF BURIAL: Sept 2 1927

20 UNDERTAKER: H W Coulson

ADDRESS 2238 Pres

Spec.—12-9-25—A Co.—200 Bks.

E 25204 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. E 25204

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp 25-12 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph E. McKeever

(a) RESIDENCE NO Ferndale Ave & 2nd St. Ward Non Res

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margt McKeever

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Store

(c) Name of employer Self

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Patrick McKeever

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Alice Smith

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Mrs Jos E McKeever

(Address) 208 Augusta Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1927, to Aug 31 1927, that I last saw h alive on Aug 31 1927, and that death occurred, on the date stated above, at 1.35 P m.

The CAUSE OF DEATH* was as follows: Cerebral Thrombosis from Uremia

CONTRIBUTORY (Secondary) Carcinoma of Pancreas (duration) yrs. 4 mos. ds.

(duration) yrs. mos. 2 1 ds.

18 Where was disease contracted (if not at place of death) Home

Did an operation precede death? Yes Date of Aug 24-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ogden R. Mortimer, M. D.

, 19 (Address) 530 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlin Cemetery Date of Burial Sept 3, 1927

20 UNDERTAKER F. A. Kwane & Son ADDRESS 703 Hanover

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25205

CERTIFICATE OF DEATH

E 25205

1-PLACE OF DEATH Hospital for the Women of Maryland REGISTERED NO. 1927

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Brooks

(a) RESIDENCE NO. Aged Women's Home Calhoun & Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: not known.

6 DATE OF BIRTH (month, day, and year): June 14, 1852

7 AGE: 75 Years 2 Months 17 Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Adams Co, Pa.

(State or country)

PARENTS

10 NAME OF FATHER: Elias Gardner

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Adams Co Pa.

12 MAIDEN NAME OF MOTHER: Hannah Hartzell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Cumberland, Md

14 Informant: Aged Woman's Home

(Address): Calhoun & Lexington Sts.

15 Filed SEP 1 1927, 19 (C. HAMILTON JONES, M. D.) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1927, to Aug. 31, 1927, that I last saw her alive on Aug. 31, 1927, and that death occurred, on the date stated above, at 1:39 P. m.

The CAUSE OF DEATH* was as follows:

Intertrochanteric fracture of right femur

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Aged Woman's Home Calhoun & Lexington St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray.

(Signed) F. H. Krouk, M. D.

8/31, 1927 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — Date of Burial: Sept 7 1927

20 UNDERTAKER: George J Smith — ADDRESS: 1532 Harlem

very important. See instructions on back

Spec.—1-10-21—M&T—1500 Blks.

Johns

E 25206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 25206
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 726½ Fremont St. WARD 17-16)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Johns

(a) RESIDENCE NO. 726½ Fremont ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 8yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER William Johns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jane Harding
(Address) 726½ Fremont

15 Filed SEP 1 - 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927, to Aug 27, 1927, that I last saw him alive on Aug 27, 1927, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Dr. Wm E. Wagner, M. D.

Aug 29, 1927 (Address) 1420 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Sept 1 1927

20 UNDERTAKER — ADDRESS 96

Saint Peters Home

Spec.—1-12-23—M&T—500 Blks.

E 25207 HEALTH DEPARTMENT—CITY OF BALTIMORE 90

E 25207

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Race ST. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Gatewood

(a) RESIDENCE NO. 1107 Race St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Rachel Gatewood.

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 60; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Planner

(b) General nature of industry, business, or establishment in which employed (or employer): Oto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Melvina Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Rachel Gatewood 1107 Race St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1st, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 25th, 1927, to Sept 1st, 1927, that I last saw him alive on Aug. 31st, 1927, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic aortic insufficiency

(duration) — yrs. 2 mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examinations

(Signed) Otony Leeibel M. D.

1, 1927 (Address) (224) Stanwood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 9/3 1927

20 UNDERTAKER: Howard Easton

ADDRESS: 916 Race

Spec.—1-12-23—M&T—500 Bks.

E 25208 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25208

CERTIFICATE OF DEATH.

1724

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Harvey Chalmers

(a) RESIDENCE No. 108 Illinois St ST., WARD Manhattan Ky

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of ~~not Married~~ Anna Gay

6 DATE OF BIRTH (month, day, and year) Nov 1 1849

7 AGE 77 Years 10 Months Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER James Chalmers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1927, to Sept 1, 1927, that I last saw him alive on Sept 1, 1927, and that death occurred, on the date stated above, at 12 15 P- m.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? general laboratory

(Signed) R Hoopes Fenn M.D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Amsterdam New York — DATE OF BURIAL: Sept 1 1927

20 UNDERTAKER Henry H Jenkins Sons — ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

E 25209

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

179 E 25209

1-PLACE OF DEATH

City of BALTIMORE: (No. 107 W. Hamburg St. 73-31 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles A. Reprogel.

(a) RESIDENCE NO. 107 W. Hamburg St. St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) February 23, 1925.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	2	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Reprogel.

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Illinois.

12 MAIDEN NAME OF MOTHER Josephine Albert.

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Baltimore, Md.

14 Informant Josephine Reprogel. (mother)
(Address) 107 W Hamburg St.

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:
Scalds about the body and buttocks. Accidental fall into a tub of hot water.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.
(Coroner)

8/21 19 27 (Address) 1017 E. Charles St.

•State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: Sept 1st 19 27

20 UNDERTAKER: C. Schumann Son ADDRESS 1034 Hanover

Spec.–7-17-26—A Co.—200 Bks.

E 25210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 25210

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. No 37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Weller

(a) RESIDENCE NO. 309 S 12th St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William C. Weller

6 DATE OF BIRTH (month, day, and year): July 17, 1877

7 AGE — Years: 50 — Months: 1 — Days: 14

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Virginia

(State or country)

PARENTS

10 NAME OF FATHER: Christian Shaw

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Matilda

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Hospital Records

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 8-31-'27

17 I HEREBY CERTIFY, That I attended deceased from 8-23-, 19 27 to 8-31-, 19 27

that I last saw her alive on 8-31-, 19 27

and that death occurred, on the date stated above, at 1.45 p m.

The CAUSE OF DEATH* was as follows:

Bilateral Pulmonary Lobar and Lobular Pneumonia

(duration) 1 week 1 day mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. Bolduan M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Sept 3 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St

Very Important. Be sure to fill out all items.

C. H. Lemmon Jones, M. D.

1927 Par RPR

Spec.—1-10-21—M&T—1500 Bks.

E 25211

E 25211

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25211

CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 14 So 11th (ST.) N-27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene M Conway

(a) RESIDENCE NO. 14 So 11th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 29 1927

7 AGE: Years — Months — Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Earl Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Nellie Emrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mr. Earl Conway (Address) 14 So 11th St

15 Filed . . . . , 19 . . . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1927, to Sept 1, 1927, that I last saw him alive on Sept 1, 1927, and that death occurred, on the date stated above, at 10.50 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J H C Mundy, M. D.

1, 19 (Address) 330 E Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cem.

DATE OF BURIAL: Sept 2nd, 1927

20 UNDERTAKER: John J Cowan & Son

ADDRESS: 90 Hollins St

C. HAMPSON JONES, M. D.

2-1927

KWK

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25212

CERTIFICATE OF DEATH.

101-001 E 25212

1-PLACE OF DEATH

City of BALTIMORE: (No. 542 So. Mary St., St., 17-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Coloreus Washington

(a) RESIDENCE NO. 542 So. Mary's St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Washington

6 DATE OF BIRTH (month, day, and year) about 1893

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice Cream Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dorcheus

9 BIRTHPLACE (city or town)

(State or country) Penna.

PARENTS

10 NAME OF FATHER John Washington

11 BIRTHPLACE OF FATHER (city or town)

(State or country) South Kuron.

12 MAIDEN NAME OF MOTHER Eliz. Gordon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Ethel Washington

(Address) 542 So. Mary St.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Aug 31, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

18 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Date of Burial Sept 3 1927

20 UNDERTAKER Samuel T. Hensley ADDRESS W. Baltimore

Spec.—1-12-23—M&T—500 Bks.

E 25213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-002

E 25213

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 18-16 ST., WARD)

REGISTERED No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dominic Ginforte

(a) RESIDENCE No. 1010 W. Fayette ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1, 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	5	7	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chicago

PARENTS
10 NAME OF FATHER Frank Ginforte
11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy
12 MAIDEN NAME OF MOTHER Monino
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank Ginforte
(Address) 1010 W Fayette St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1927, to Sept 1, 1927, that I last saw him alive on Sept 1, 1927 and that death occurred, on the date stated above, at 5 25 0 m
The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Pharyngeal Diphtheria (duration) yrs. mos 11 ds.
CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical appearance.

(Signed) Myron G. Hill, M. D
9/1, 1927 Address Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 3 19 27

20 UNDERTAKER: Mr - Mrs N S Ginft — ADDRESS: [illegible]

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25214

CERTIFICATE OF DEATH

100-001

E 25214

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] BALTIMORE CITY HOSPITALS Ward) 9-17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Cassady

(a) RESIDENCE NO. 1315 W. Eden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/10 1890.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sign painter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer 0 50

9 BIRTHPLACE (city or town) New York

(State or country) New York

PARENTS

10 NAME OF FATHER Jno. R. Cassady

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) BALTIMORE CITY HOSPITALS Records Office

15 Filed ..... 19 .....

Registrar

SEP 2 1927 C. H. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1927 to Sept. 1, 1927, that I last saw him alive on Sept. 1, 1927 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Swollen pneumonia - epidural

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Alcoholism

(Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gram + Smear

(Signed) C. Hubert Burgel, M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Marys Govans

Date of Burial 9/5 1927

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford

Spec.—7-17-26—A Co.—200 Bks.

E 25215

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-002

REGISTERED NO. E 25215

1-PLACE OF DEATH Union Memorial Hosp. 13-59

City of BALTIMORE: (No. 33rd & Calvert St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Russell Almond

(a) RESIDENCE NO. 3539 Everhart St. Ward Infant.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7, 1927

7 AGE Years Months 6 weeks Days 2d

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland-City

(State or country)

PARENTS

10 NAME OF FATHER William Almond

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lizzie Cottage

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Records

(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 27 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1927, to Sept 1, 1927, that I last saw h[illegible] alive on Sept 1, 1927, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute intestinal Indigestion & Diarrhea

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. J. Belford, M. D.

9-1, 1927 (Address) Union memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert

Date of Burial 9/2 1927

20 UNDERTAKER William Carr

ADDRESS 502 E Baltimore

Very Important: See instructions on back

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25216

CERTIFICATE OF DEATH

41 E 25216

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 652 Portlend ST. 22-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.

2-FULL NAME Arthur F. Mistof

(a) RESIDENCE No. 652 Portlend ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15. 1919

7 AGE 7 Years 10 Months 15 Days 16 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leon Mistof

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER C. Waitkaitis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant C. Mistof

(Address) 652 Portlend Street

15 Filed Aug 31, 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1927, to Aug. 31, 1927, that I last saw him alive on Aug. 31. 1927, and that death occurred, on the date stated above, at 4. p m

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Infection in foot.

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) M. Friedman M. D.

9/1, 1927 (Address) 652 Wrhgt Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept. 3. 1927

20 UNDERTAKER: John Greblauckas — ADDRESS: J G. 425 S Paca St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25217

CERTIFICATE OF DEATH

1855

E 25217

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 216 Augusta Ave. St., Ward) Irving 10-1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph G. Dumler

(a) RESIDENCE NO. 216 Augusta Ave. Irving St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 4 mos. 5 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Sophia M. Dumler

6 DATE OF BIRTH (month, day, and year): April 26 1862

7 AGE: Years 65 Months 4 Days 5 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Furniture Manufacturer

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. (State or country) Md

PARENTS

10 NAME OF FATHER: Joseph Dumler

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary A Kisener

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Sophia M. Dumler (Address) 216 Augusta Ave. Irving Co

15 Filed SEP 2 - 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 31 1927

17 I HEREBY CERTIFY, That I attended deceased from August 7, 1927, to August 31, 1927, that I last saw h alive on August 31, 1927, and that death occurred, on the date stated above, at 8.55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage following a fall

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Edward J Stahl, M. D.

(Address) 210 W Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Sept 3 1927

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25218

CERTIFICATE OF DEATH.

1929 E 25218

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 7 Rosekemp ave ~~St.~~ 27-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Bell Hall

(a) RESIDENCE. No. 7 Rosekemp ave ~~St.~~ WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Ethelbert Hall

6 DATE OF BIRTH (month, day, and year): Dec 31-79

7 AGE — Years: 47 — Months: 7 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm E. Vincent

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Antoinette

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Ethelbert Hall 7 Rosekemp ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 28. 1927. to Aug 30 1927.

that I last saw her alive on Aug 30 1927.

and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Uremia Brights Disease Endocarditis Intestinal obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wade Hinkley, M. D.

Sept. 1927 (Address) 1328 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: 9/2 1927

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Allendale St.

SEP 2 - 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25219

CERTIFICATE OF DEATH

139

E 25219

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St., BALTIMORE CITY HOSPITALS Ward) 17-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ceana Stanley

(a) RESIDENCE NO. [redacted] St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 46 Months Days IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address) BALTIMORE CITY HOSPITALS [redacted]

15 Filed SEP 2 - 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31, 1927

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible], to [illegible], 19[illegible],

that I last saw h[illegible] alive on [illegible], 19[illegible],

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Uraemia

Nephritis - Chronic

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Holmes Bunce, M. D.

19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial: Sept 4 1927

20 UNDERTAKER: J. P. T. Rochester — ADDRESS: 1413 Jefferson St

pec.—1-12-23—M&T—500 Bks.

205858

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25220

CERTIFICATE OF DEATH.

100-001

E 25220

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRANK GEGOREK

(a) RESIDENCE No. 837 S. Dallas St ST., ... WARD 7

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widower

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Frances Gegorek

6 DATE OF BIRTH (month, day, and year): Oct 4- 1862

7 AGE: Years 64 | Months 10 | Days 27 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Repair Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: 0 ? 6

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Frances Ramosa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Records (Address)

15 Filed ... 19 ... JOHNS HOPKINS HOSPITAL ... M. D. Registrar

K W K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/31 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug-8, 1927, to Aug 31, 1927, that I last saw h(er) alive on Aug 31, 1927, and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

Of. by Bronchopneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage and Bronchopneumonia (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Guaiac on stool + vomitus X-ray of chest.

(Signed) Raymond Wing. M. D.

8/31, 1927 (Address) Johns Hopkins Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: 9/3 1927

20 UNDERTAKER: 1129 Fairlow Ave 1618

ADDRESS: Govans

pec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 25221

E 25221

CERTIFICATE OF DEATH. 23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 2-4 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Treidzinska

(a) RESIDENCE NO. 1723 Alice Ann ST., WARD City
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-27-26

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Leo Treidzinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Agnes Zythich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Reeds -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1927, to Aug 31, 1927, that I last saw h-e alive on Aug 31, 1927 and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis
Sepsis

over

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Sept 2-

DATE OF BURIAL 19

20 UNDERTAKER F W Ozgewski

ADDRESS 1930 Eastern Ave

Cor.—12-9-25—A Co.—200 Bks

Cor.—12-9-25—A Co.—200 Bks.

Time of burial extended to Monday Sept. 5/27. J. Frederick Stumpf

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25222
1-PLACE OF DEATH

E 25222
REGISTERED NO.

City of BALTIMORE: (No. Duncan Woods-Nr Orangeville St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Cole

(a) RESIDENCE NO. 1512 N. Montford Ave St. 8-16 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Cole

6 DATE OF BIRTH (month, day, and year) Oct 31/1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
54	55	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter 67
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. Hotel Grocery Co

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Cole

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Elizabeth A. Froud

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Wm. F. Cole, Jr.
(Address) 1512 N. Montford Ave

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 About May 21/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis. (Exposure, found in Duncan woods on Sept 1/27. He had been ailing for some time.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. (May 19/27)

(duration) yrs. mos. ds.

(Signed) J. J. Cole M. D.
(Coroner)

9/2/27, 19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Sept 3 19 27

20 UNDERTAKER Edward G. Fink Address 134 Fulton Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25223

CERTIFICATE OF DEATH.

74-001

E 25223
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 318 N. Garrison Ave St., 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Virginia Edwards

(a) Residence No. 318 N. Garrison St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Fleming Edwards

6-DATE OF BIRTH (month, day and year) June 7/44

7-AGE. 83 yrs. 2 mos. 30 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Wm. Walker

11-BIRTHPLACE OF FATHER (city or town) Va
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Cockell

13-BIRTHPLACE OF MOTHER (city or town) Va
(State or Country),

11- (Informant) Chas. L. Smith

(Address) 3/ S. Carrison Ave

15- Filed 6-2-1927 192 R.H.L. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 1 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1926 to Sept 1 1927

that I last saw her alive on Sept 1 1927

and that death occurred, on the date stated above, at 7.45 p. m.

The CAUSE OF DEATH* was as follows:

Senile Cardio, renal insufficiency

304
(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. 3 mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. E. Knipp M. D

Sept 2 192 (Address) 1035 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. Sept 3 192

20-UNDERTAKER. John Tumm

ADDRESS 1 W Pratt

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25224

CERTIFICATE OF DEATH.

90

E 25224

1-PLACE OF DEATH

City of BALTIMORE: (No. 2234 Barclay St., 12-50 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Marie Becker

(a) RESIDENCE NO. 2234 Barclay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): October 24 1911

7 AGE: Years 5 Months 10 Days 7 6

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: John F. Becker

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Mary J. Burke

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland

14 Informant: John F. Becker

(Address) 2234 Barclay St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Aug 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1923, to Aug. 30, 1927, that I last saw h.. alive on Aug. 28, 1927, and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis

Mitral and aortic insufficiency

(duration) 4 yrs. 0 mos. 10 ds.

CONTRIBUTORY —

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Alexander J Schaffer, M. D.

, 19 (Address) 1814 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial: Sept 3 1927

20 UNDERTAKER: Mary M. Wadefield ADDRESS 501 E 22nd St

Spec.—1-12-23—M&T—500 Blks.

E 25225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 25225

1-PLACE OF DEATH Home for Incurables ? Baltimore City

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 40th st + Cedar Ave ST. 13-32 WARD)

2-FULL NAME Olivia Virginia Chenoweth

(a) RESIDENCE NO. Home for Incurables ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	80	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robert M. Chenoweth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Anne Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs Home for Incurables
(Address) Somerset Road

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to Aug 31, 1927, that I last saw h[illegible] alive on August 31, 1927, and that death occurred, on the date stated above, at 10.25 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma (?) of left kidney —

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Secondary anemia

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam. Exam of blood + urine

(Signed) R W B Mercer M. D.

Aug 31/1927 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL Sept 5 1927

20 UNDERTAKER J. J. Tucker & Son — ADDRESS [illegible]

Cor.—12-9-25—A Co.—200 Bks.

E 25226

HEALTH DEPARTMENT—CITY OF BALTIMORE

57 E 25226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2003 Boone St St., 9-46 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry E. Jacoby

(a) RESIDENCE NO. 2003 Boone St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 93 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of [redacted] Fanny E. Jacoby

6 DATE OF BIRTH (month, day, and year) Feb 28/1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegrapher

(b) General nature of industry, business, or establishment in which employed (or employer) Penna R.R.

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) York, Pa

PARENTS

10 NAME OF FATHER Samuel Jacoby

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) York, Pa.

12 MAIDEN NAME OF MOTHER Ellen Ehrman

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) York, Pa.

14 Informant Claire E. Jacoby,

(Address) 621 Linnard St

15 Filed_____, 19____ 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mel (duration) yrs. mos. ds.

(Signed) Jos Collins M. D. (Coroner)

9/2/1927 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cmetery York Pa Date of Burial Sept 5th 1927

20 UNDERTAKER George Schilling & Sons ADDRESS 1126 E Monument St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25227

CERTIFICATE OF DEATH.

18 E 25227

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Found in water Pier 4 foot St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME unknown

(a) RESIDENCE NO. unknown St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: about 45 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed, 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found Aug 24. 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an unknown (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said unknown (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned

probably accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. J. Kelly M. D.

(Coroner)

Aug 31, 19 27 (Address) 1039 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY Date of Burial 19

20 UNDERTAKER ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

E 25228

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. St. 18 Ward)

REGISTERED NO. 1671

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Wise

(a) RESIDENCE No. 315 N. Carey St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 27 '27

7 AGE: Years | Months | Days: 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Robert Stanley Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Anna Rockwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): Anna Wise 315 N. Carey St.

15 Filed , 19 1671 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 1 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27 19 27 to Sept. 1 19 27

that I last saw him alive on Sept. 1 19 27

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Prematurity

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Margaret B. Ballard M. D.

19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL 19

20 UNDERTAKER | ADDRESS

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

25229 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25229

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1104 N. Gaves St. ST. 21-24 WARD)

2-FULL NAME Charles Harrison

(a) RESIDENCE NO. 1104 N. Gaves ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Harrison

6 DATE OF BIRTH (month, day, and year) April 22-1858

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	4	9	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Chas Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER M. Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Rev. Minnie Harrison (wife) (Address) 1104 N. Gaves St.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/31 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/30, 1927, to 8/31, 1927, that I last saw him alive on 8/16, 1927 and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Francis A. Scarlett, M. D.

, 19 (Address) 937 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 9/3/27

20 UNDERTAKER Geo. Lumbrick & Son — ADDRESS 525 N. Lynchburg

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25230

CERTIFICATE OF DEATH.

E 25230

21-29 / 18-093

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August W. Kunz.

(a) RESIDENCE NO. 1229 Cleveland St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ------- mos. ------- ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) July 18, 1912.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	15	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) New York.

PARENTS

10 NAME OF FATHER Samuel Kunz.

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Switzerland.

12 MAIDEN NAME OF MOTHER Martha Richter.

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Germany.

14 Informant Samuel Kunz. (father)

(Address) 1229 Cleveland St.

15 Filed ..... 19 .....

1927 REH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) August 31, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull. Accidentally struck, knocked down and run over by an electric truck while riding a bicycle.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto F. Paulsen, M. D.

(Coroner)

9/2 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the state ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Hamburg near Eterrett st Aug. 31, 1927

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Sept 3 1927

20 UNDERTAKER Mr & Mrs. John H. Teufel & Son ADDRESS 801 W. Fayette

Spec.–7-17-26—A Co.—200 Bks.

E 25231

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60-001

E 25231

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 570 N. Gay St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Wettern

(a) RESIDENCE NO. 570 N. Gay St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 6 mos. 24 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Otto Wettern

6 DATE OF BIRTH (month, day, and year): Feb 7 1875

7 AGE — Years: 52 Months: 6 Days: 24 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Holle

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Keyes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant (Address): Otto Wettern 570 N. Gay St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 30, 1927, to Aug 31, 1927, that I last saw h[illegible] alive on Aug 30, 1927, and that death occurred, on the date stated above, at 5-0 a. m.

The CAUSE OF DEATH* was as follows:

Toxic Goitre

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Carbuncle

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy, M. D.

(Address) 800 Eutaw St

Sept 1, 27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — Date of Burial: Sept 3 1927

20 UNDERTAKER: Sos Sourdens Son — ADDRESS: 217 S. Ba

Spec.–7-17-26—A Co.—200 Bks.

25232

HEALTH DEPARTMENT—CITY OF BALTIMORE

25232

CERTIFICATE OF DEATH

X 16-007

REGISTERED NO. 12-49

1-PLACE OF DEATH Union Mem. Hosp.

City of BALTIMORE: (No. 330 Calvert St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby. Virginia Knapp.

(a) RESIDENCE NO. Forest Hill. Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 2/27

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Harford Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER Ernest

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Harford Co Md.

12 MAIDEN NAME OF MOTHER Riley Grafton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Harford Co Md.

14 Informant Riley

(Address)

15 Filed , 19 Registrar

C. HAMILTON JONES, M. D.

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Sept 2/27.

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1927, to Sept 2, 1927, that I last saw h[illegible] alive on Sept 2, 1927, and that death occurred, on the date stated above, at 4.38 P. m.

The CAUSE OF DEATH* was as follows: Acute intestinal indigestion

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. O. Hannah, M. D.

, 19 (Address) Union memorial Hosp. 33d & Calvert Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestnut Hill Md. Date of Burial Sept 3 1927

20 UNDERTAKER Harford Co Decm & Foster ADDRESS Bel Air Md

Spec.–7-17-26—A Co.—200 Bks.

E 25233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

58-001

E 25233

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] Street [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Cook.

(a) RESIDENCE NO. 60 N Spring Street Ward

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen R. Cook

6 DATE OF BIRTH (month, day, and year) ? 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Frederick Cook

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah Cain ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [redacted]

15 Filed [illegible], 19 [illegible] CHARLTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/ 1927

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1927, to Sept. 1, 1927

that I last saw him alive on Sept. 1, 1927

and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious anaemia

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General & Sect.

(Signed) C. Holland Deaver, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Baltimore Cem. Date of Burial Sept 3 1927

20 UNDERTAKER [illegible] ADDRESS [illegible]

Spec.-7-17-26—A Co.—200 Blks.

E 25234

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 25234

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St. 26-37 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Antun

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) [redacted] (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
81	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) South America

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) [redacted]

15 Filed 2 1927, 19

Registrar

ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/1927.

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1927, to Sept. 1, 1927

that I last saw him alive on Sept. 1, 1927

and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Sect

(Signed) C. Hendon Bond, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Laurel Memorial Park 9/3 1927

20 UNDERTAKER — ADDRESS

J. F. Slaughter 1318 Eight

Cor.—12-9-25—A Co.—200 Bks.

E 25235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital 26-34 Ward)

REGISTERED NO. 184-003 E 25235

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mario Castello

(a) RESIDENCE NO 911 N-12th St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1920

7 AGE: Years 7; Months; Days; IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Petro Castello

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Elizabeth Conte

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Petro Castello

(Address) 911 N 12th St

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc.

Fracture of Skull

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) Geo. Elmer T. Pickel M. D.

(Coroner)

(Address) 1436 N Stray

Sept 1/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer. Date of Burial: Sept 5th 1927

20 UNDERTAKER: Leo G. Crook ADDRESS 1723 Patt Pk Ave

Dec 1927 C. Heaton Jones M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25236

CERTIFICATE OF DEATH

129

E 25236

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospital St., 2-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm F Ellinghaus

(a) RESIDENCE NO. 504 N. Collet St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 77 Years Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nail

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER Carl Ellinghaus

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Meyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant: Julia Ellinghaus

(Address) 504 N. Collet St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-3-, 1927, to 9-1-, 1927, that I last saw him alive on 9-1-, 1927, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Edematized

Arteriosclerosis Chronic Myocarditis

Contributory: Bronchopneumonia

(duration) mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) J. B. Lincoln, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Sept 3rd 1927

20 UNDERTAKER: Leo G. Brook — ADDRESS: 1723 Patterson Park Ave

Very important: See that all questions are answered.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25237.

CERTIFICATE OF DEATH.

90 E 25237

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 126 S Dallas St. 34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Wilds

(a) RESIDENCE NO. 126 S Dallas St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Oyster Shucker
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant John E Smallwood
(Address) 1577 E Pratt st

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Exhaustion (duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. 1 ds.

Signed ... M. D.
(Coroner)
Sept 4 19 27 (Address) 143 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury — Date of Burial Sept 4 19 27

20 UNDERTAKER John W Henderson — ADDRESS 1503 E Monument

1927

Spec.—1-10-21—M&T—1500 Bks.

E 25238

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25238

CERTIFICATE OF DEATH.

101-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Dolphin ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Gantt

(a) RESIDENCE No. 515 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 13-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Wm Gantt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Inez Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Wm Gantt 515 Dolphin St

15 Filed 1927 C. W. WATSON JONES, M. D. Registrar RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 26, 1927, to Sept 2, 1927, that I last saw h[illegible] alive on Sept 2, 1927, and that death occurred, on the date stated above, at 4.45 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms & Physical signs

(Signed) [illegible], M. D.

, 19 (Address) 714 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Sept 4 1927

20 UNDERTAKER John H. Joseline

ADDRESS 1027 Woodall

Spec.–7-17-26—A Co.—200 Bks.

E 25239

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25239

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balt City Hospital St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elijah Bannister

(a) RESIDENCE NO. 1401 N. Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE Years 57 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Shoo Bannister

11 BIRTHPLACE OF FATHER (City or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Priscilla Brany

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant Mrs Bannister

(Address) 1401 Fremont Ave

15 Filed 1927 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 8-31-27

17 I HEREBY CERTIFY, That I attended deceased from 7-21-, 1927, to 8-31, 1927

that I last saw h alive on 8-31-, 1927

and that death occurred, on the date stated above, at 4:55 p. m.

The CAUSE OF DEATH was as follows:

Carcinoma Right Side of face,

Contributory mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. Blevins, M. D.

, 19 (Address) Balt City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial: Sept 3 1927

20 UNDERTAKER: Samuel Hemsley ADDRESS: Biddle

Spec.–7-17-26—A Co.—200 Bks.

E 25240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

59-207

E 25240

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Camp Holabird St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Rotte

(a) RESIDENCE NO. Camp Holabird St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9th 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	1	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Walter Reed Hospital

(State or country) Wash. D. C.

PARENTS

10 NAME OF FATHER Sergt Albert Rotte

11 BIRTHPLACE OF FATHER (City or town) Newport Ky.

(State or country)

12 MAIDEN NAME OF MOTHER Theresa C. Malone

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

14 Informant Sergt Albert Rotte

(Address) Camp Holabird

15 Filed ....., 19 .....

Registrar

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31st 1927

17 I HEREBY CERTIFY, That I attended deceased from April 4th, 19 27, to August 31st, 19 27,

that I last saw him alive on Au ust 30th, 19 27,

and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Status thymicolymphaticus

(Mongolian Idiot)

(Pati nt foramen ovale)

(duration) 1 yrs. 8 mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Capt. M.C., M. D.

Sept 1/27 (Address) Station Hospital, Camp Holabird, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Oak Lawn Cemetery	Sept 3rd 1927
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	1633 Wash Ave

ec.—1-12-23—M&T—500 Bks.

E 25241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1124 E 25241

REGISTERED NO. 227-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 E. Woodland Ave. Sept. WARD)

2-FULL NAME William Jackson Skull

(a) RESIDENCE NO. 203 E. Woodland Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Laura S. Skull

DATE OF BIRTH (month, day, and year) May 21, 1867

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	3	10	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O. R. R.

8 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Harry Skull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jane Dean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Laura S. Skull

(Address) 203 E. Woodland Ave.

15 Filed ____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1927. to Sept. 1, 1927.

that I last saw him alive on Sept. 1, 1927

and that death occurred, on the date stated above, at 6.20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James S. Ashcraft, M. D.

9-3, 1927 (Address) 4012 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery | DATE OF BURIAL Sept 3 1927

20 UNDERTAKER Wm Hechter & Sons. | ADDRESS North Ave

Cor.—12-9-25—A Co.—200 Bks.

E 25242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25242

REGISTERED NO. 21423

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

2-FULL NAME Douglass T. Watkins.(C)

(a) RESIDENCE NO. Ijamsville, Frederick Co, Md. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ---; ------ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	Colored	Married.

5a If married, widowed or divorced (HUSBAND) of (XXXXXXXX) Marguerit Watkins.(C)

6 DATE OF BIRTH (month, day, and year) October 31, 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	41	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Frederick Co. Md

PARENTS

10 NAME OF FATHER Samuel Watkins.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rachael Bowman.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Marguerit Watkins,(C) wife.

(Address) Ijamsville Frederick Co. Md.

15 Filed ..... 19 .....

1321 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 1, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Compound fracture of tibia, fibula and femur of right leg. Run over while attempting to board a moving automobile truck. Occidental death.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas M Kennard M. D.

(Coroner)

9/8 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Chesapeake Ave nr. 9th St. Brooklyn.

Former or usual residence Aug. 21, 1927.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ijamsville Md Date of Burial 9-9- 1927

20 UNDERTAKER W. E. Falconer. ADDRESS 111 Market St.

pec.—1-12-23—M&T—500 Bks.

E 25243

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25243

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 97-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Wieland

(a) RESIDENCE NO. 245 Oread Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 13, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		18 mo		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Frank Wieland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gertrude Van Gorder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Father (Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1927. to Sept 1, 1927. that I last saw h er alive on Sept 1, 1927 and that death occurred, on the date stated above, at 8 00 P m.

The CAUSE OF DEATH* was as follows:

Entero - Colitis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Campbell Goodwin, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Sept 3 1927
20 UNDERTAKER	ADDRESS
Harry H Witzke	1531 N Fulton Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25244

CERTIFICATE OF DEATH.

182 E 25244

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1712 N. Franklin St. 14-27 Ward)

2-FULL NAME Wm. J. Boston Jr.

(a) RESIDENCE NO. 1712 N. Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 26, 1925

7 AGE — Years: 2 Months: 1 Days: 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Md.

10 NAME OF FATHER Wm. J. Boston

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Penna

12 MAIDEN NAME OF MOTHER Alice Kirk

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

PARENTS

14 Informant: Wm. J. Boston

(Address): 1712 N. Franklin St.

Filed....., 19.....

SEP 3 - 1927

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning;
fell into wash tub;

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) 0

(duration) .....yrs. .....mos. .....ds.

(Signed) J. J. Hennessy (Coroner) M. D.

Sept, 1927 (Address) 25 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — Date of Burial: Sept 4 1927

20 UNDERTAKER: Joseph A. Levely — ADDRESS 737 N. Monroe

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25245

CERTIFICATE OF DEATH.

113 E 25245

1-PLACE OF DEATH

City of BALTIMORE: (No. 1140 Russell St. St. 21-31 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Miller.(C)

(a) RESIDENCE NO. 1140 Russell St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) March 6, 1927.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	0	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Miller.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Vera Jones.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Vera Miller.(C) mother.

(Address) 1140 Russell St.

15 Filed_____, 19 27 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 1, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Indigestion

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Otto T. Bernard M. D. (Coroner)

9/8, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion es Date of Burial 9/1-3 1927

20 UNDERTAKER Chas Brown & Son ADDRESS Mt. Holly

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 25246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 E 25246

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1140 Russell St. 21-31 Ward)

2-FULL NAME James Miller.(C)

(a) RESIDENCE NO. 1140 Russell St. St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 26 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) March 6, 1927.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	0	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Miller.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Vera Jones.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Vera Miller.(C) mother.
(Address) 1140 Russell St.

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 1, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Indigestion

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) _____

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Leonard M. D.
(Coroner)

9/3 , 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
In place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Date of Burial 9/3 19

20 UNDERTAKER J. S. Brown & Sons ADDRESS

Spec.—1-12-23—M&T—500 Blks.

25247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | E 25247

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1109 (St.) Battery Ave (WARD) 24

REGISTERED NO. 24432

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Allen

(a) RESIDENCE No. 1109 (St.) Battery Ave WARD 24

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: William A Allen

6 DATE OF BIRTH (month, day, and year): June 10 1864

7 AGE: Years 63 | Months 2 | Days 23 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Benjamin Schreckels

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mary Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: William A Allen

(Address): 1109 Battery Ave.

15 Filed , 19 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9 - 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from 8.15.22, 19 , to 9.2.27, 19 ,

that I last saw h-- alive on 8.30.27, 19

and that death occurred, on the date stated above, at 4 a. m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Diabetes

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 7 39 2. Fort Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only Microsc. & Chemical

(Signed) C. Lilip. B. Mullen, M. D.

9.2.27, 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: 9-5th 1927

20 UNDERTAKER: E & B Hale

ADDRESS: 115 E Lexington St

Spec.–7-17-26—A Co.—200 Bks.

Kabe Schlum.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25248
1-PLACE OF DEATH

CERTIFICATE OF DEATH

117

E 25248
REGISTERED NO.

City of BALTIMORE: (No. Jud General 1927 St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kabe Schlum

(a) RESIDENCE NO. 1104 Eutaw Place St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Kabe Schlum

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 45 Months ? Days ?

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abram Isaac Schlum

11 BIRTHPLACE OF FATHER (City or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah Millman

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Russia

14 Informant: Hospital Records
(Address)

15 Filed 4 1927, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Sept 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 19 27, to Sept 2, 19 27, that I last saw h... alive on Sept 2, 19 27, and that death occurred, on the date stated above, at 6:13 P. m.

The CAUSE OF DEATH* was as follows:
Appendicitis Abscess
?
? (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Peritonitis
? (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-2-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.
(Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cem

Date of Burial: 9/4 19 27

20 UNDERTAKER: Jack Levis

ADDRESS: 1434 Eutaw St

E 25249 Lillie Hawkins

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

90E 25249

1 PLACE OF DEATH — Registered No. C.....

CITY OF BALTIMORE: (No. 306 W Preston St 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie Hawkins

(Residence in Baltimore: No. 306 W Preston St St.; 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: ? (Month) (Day), 1881 (Year)

7-AGE: 46 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: Corbey

11-BIRTHPLACE OF FATHER (State or country): ~~Jenifer~~ Md.

12-MAIDEN NAME OF MOTHER: Jenifer

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Nannie Brown

(Address) 1011 Linden Ave

15-

Filed ..... 191 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept (Month) 2 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April, 1927, to, Sept. 2 1927, that I saw her alive on Sept 3 1927, and that death occurred, on the date stated above, at 0 m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia. Fallow Myocarditis

Duration: April 1927 mos. ds

Contributory (SECONDARY) Pneumonia

Duration: ~~1927~~ yrs mos ds

(Signed) W K Fowler M. D.

9/3 1927 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 9/5/27 191

20-UNDERTAKER: Mrs. Geo. L. Holland — ADDRESS: 1632 Druid Hill Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25250

CERTIFICATE OF DEATH.

51 V

REGISTERED NO. E 25250

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 N Mount ST. 15-27 WARD)

2-FULL NAME Dennis M. Jones Jr.

(a) RESIDENCE NO. 1319 N Mount ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 23 1916

7 AGE — Years: 11 — Months: 4 — Days: 9 — If LESS than 1 day, ... hrs or ... min.: 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer): (none)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Dennis M Jones Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Corine A Todd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mrs Louise Todd (Grandmother)
(Address) 13 19 N Mount.

15 Filed Sept 4 1927 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1927

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1927, to Sept 2, 1927, that I last saw him alive on Aug 31, 1927, and that death occurred, on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis & Pericardial Effusion

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) unknown

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Gorman, M. D.

Sept 4 1927 (Address) 1429 E monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norfolk, Va. — DATE OF BURIAL: Sept 6 1927

20 UNDERTAKER: Jno. Ges. H. Holland — ADDRESS: 1631 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25251

CERTIFICATE OF DEATH.

90 E 25251
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Motherhouse of Notre Dame ST. 10-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Emmerich Haas

(a) RESIDENCE NO. Lisquith St ST., ... WARD
(Usual place of abode)
Length of residence in city or town where death occurred 14 yrs. ? mos. ds. How long in U. S., if of foreign birth? 70 yrs. ? mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 3-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	83	9	29 30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria

PARENTS

10 NAME OF FATHER James Haas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Elizabeth Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Sister Mary Dismas
(Address) Lisquith St. City

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2- 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug-4- , 1927 , to Sept-2- , 1927 ,
that I last saw her alive on Sept-2- , 1927 ,
and that death occurred, on the date stated above, at 4.40 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Lybert , M. D.

, 19 (Address) 3302 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Md. DATE OF BURIAL Sept 5 1927

20 UNDERTAKER Frank a Fink ADDRESS 410 N. Gay

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25252

CERTIFICATE OF DEATH.

E 25252

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mother House of Notre Dame 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Valentina Steger

(a) RESIDENCE NO. Wiegmith St ST., WARD Georgetown Md.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb-2-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher 68

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rochester, N.Y.

PARENTS

10 NAME OF FATHER George Steger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Joseph Reider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sister M. Dionysia
(Address) Wiegmith St City

15 Filed SEP 4 1927, 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-3-1927

17 I HEREBY CERTIFY, That I attended deceased from August-16-, 1927, to Sept-3-, 1927, that I last saw her alive on Sept-3-, 1927, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

Arterio Sclerosis Sept (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Hyde, M. D.

, 19 (Address) 2802 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Cliff Abd. DATE OF BURIAL: Sept 6 1927

20 UNDERTAKER: Frank A. Fink ADDRESS: 410 N Gay

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25253 — 1-PLACE OF DEATH

E 25253 — REGISTERED NO.

City of BALTIMORE: (No. 1409 Eutaw Place St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Thompson Oudesluys

(a) RESIDENCE NO. 1409 Eutaw Place St. Ward Resident
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 1 mos. 6 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 72 yrs. 1 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie C. Oudesluys

6 DATE OF BIRTH (month, day, and year) July-27-1855

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	72	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles L. Oudesluys

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Waters

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Katie C. Oudesluys (wife)

(Address) 1409 Eutaw Place

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9, 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15 1927, to Sept 3 1927, that I last saw h[illegible] alive on Sept 2 1927, and that death occurred, on the date stated above, at 1.20 A.M.

The CAUSE OF DEATH* was as follows:

Malignant Tumor of Liver

3 yrs. (duration) ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) James C. Clarke, M. D.

9, 7, 1927 (Address) Lorraine Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Greenmount Cemetery	Sept-5-1927

20 UNDERTAKER ..... ADDRESS .....

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25254

CERTIFICATE OF DEATH

185 E 25254

REGISTERED NO.

E 25254
1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Louise Roberts

(a) RESIDENCE NO. 106 Cathedral St. Ward Resident
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 70 yrs. 9 mos. 14 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank X Roberts

6 DATE OF BIRTH (month, day, and year) Nov. 20 – 1856

7 AGE	Years	Months	Days 13
	70	9	14

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) New Haven
(State or country) Conn.

PARENTS

10 NAME OF FATHER Thomas Price

11 BIRTHPLACE OF FATHER (City or town) New Haven
(State or country) Conn.

12 MAIDEN NAME OF MOTHER Katherine Mallory

13 BIRTHPLACE OF MOTHER (city or town) New Haven
(State or country) Conn.

14 Informant Mrs. Mary Roberts (daughter)
(Address) 106 Cathedral St.

15 Filed ....., 19 .....

.....
Registrar

Per R H K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 19 27, to Sept 3, 19 27,

that I last saw h[illegible] alive on Sept 3, 19 27,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture neck of femur resulting from a fall at home

(duration) ....yrs. ....mos. 4 ds.

18 Where was disease contracted at residence of deceased, 106 Cathedral St.
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray.

(Signed) H S Anderson, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

Date of Burial Sept 6 1927

20 UNDERTAKER J. STEPHEN MOWEN COMPANY
WILLIAM F. WOODEN, Successor

ADDRESS 108 W. NORTH AVE

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25255

CERTIFICATE OF DEATH

+ 117 E 25255

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hosp. St., 12-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Charles Kolaclaw

(a) RESIDENCE NO. West Palm Beach, Fla. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 14 ds. How long in U. S. if of foreign birth? 61 yrs. 7 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Flood

6 DATE OF BIRTH (month, day, and year): 1865 Born - 5

7 AGE: Years 61 Months 7 Days 28 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate Dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Born in Ky. Louisville

(State or country)

PARENTS

10 NAME OF FATHER: Mr. L. Kolaclaw

11 BIRTHPLACE OF FATHER (City or town): Ky. Louisville

(State or country)

12 MAIDEN NAME OF MOTHER: Julia Clegg

13 BIRTHPLACE OF MOTHER (city or town): Ky

(State or country)

14 Informant: Mr. Chas. Kolaclaw

(Address) 603 N. Olive St. West Palm Beach Fla.

15 Filed ..... 19 ..... Registrar R P C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Sept 3 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1927, to Sept 3, 1927, that I last saw him alive on Sept 3, 1927, and that death occurred, on the date stated above, at 6.20 a m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis — c

acute circulatory collapse

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? yes Date of (Appendectomy) 8-30-27

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R P Bel Ford M. D.

9-3-27 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louisville Ky

Date of Burial: Sept 4 19 27

20 UNDERTAKER: [illegible] COMPANY

ADDRESS: [illegible] N. EIGHTH AVE.

Very Important. See instructions on back

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25256

CERTIFICATE OF DEATH

146 E 25256

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. 4-25 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Hill

(a) RESIDENCE NO. 633 Pine St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): August 28 1913

7 AGE: 14 Years / Months 4 Days 4

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER John Hill

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Minnie Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) St Marys Co

14 Informant: Emma Hill

(Address) 1151 N Carey St

15 Filed SEP 4 - 1927 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1927, to Sept 2, 1927,

that I last saw her alive on Sept 2, 1927,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pelvic Peritonitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pregnancy with Cephalic Presentation

Full term (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 29 1927

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H S Anderson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Sept 6 1927

20 UNDERTAKER: Emma E Hill ADDRESS 1151 N Carey St

Spec.–7-17-26—A Co.—200 Bks.

Dave Rianhard

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25257 CERTIFICATE OF DEATH

REGISTERED NO. E 25257

City of BALTIMORE: (No. 1116 Gen Ave St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dave Rianhard

(a) RESIDENCE NO. Chesterton St. Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Rianhard

6 DATE OF BIRTH (month, day, and year) Nov 25 1858

7 AGE

Years	Months	Days
68	9	10

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farm

(c) Name of employer self

9 BIRTHPLACE (city or town) New York City

(State or country)

PARENTS

10 NAME OF FATHER John Rianhard

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Toledo, Ohio

12 MAIDEN NAME OF MOTHER Adelade Lock

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Mary Rianhard

(Address) Chester Md.

15 Filed SEP 4 1927 19 HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-20, 1927, to 9-4, 1927, that I last saw h[illegible] alive on 9-1-, 1927, and that death occurred, on the date stated above, at 12 10 A.m.

The CAUSE OF DEATH* was as follows:

Necrotic abscess of liver - (Pyloric)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) 5 days yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 8/17/27

Was there an autopsy? yes Drawn

What test confirmed diagnosis? Microscopic Examination

(Signed) Jno A Brownlee, M. D.

Sept 4, 1927 (Address) 1116 Gen Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Long Island New York — Date of Burial Sept 4 1927

20 UNDERTAKER Henry Mfenkins Sons — ADDRESS Fremont & Collins

Spec.—1-10-21—M&T—1500 Bks.

E 25258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

70-28 13 E 25258

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 S. Monroe ST. 70 WARD)

2-FULL NAME Henry Kotan

(a) RESIDENCE NO. 106 S. Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred —— yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June 24 27

7 AGE — Years: — Months: 2 Days: 9 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles H. Kotan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Rose Vitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Charles H Kotan

(Address): 106 S Monroe St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1927, to Sept 3, 1927, that I last saw h[illegible] alive on Sept 3, 1927, and that death occurred, on the date stated above, at 9 30 p. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A Keller Hennig M. D.

9/3, 1927 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt O Cust

DATE OF BURIAL: Sept 5, 1927

20 UNDERTAKER: Geo W Little

ADDRESS: 2700 Edmondson Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

65-001

E 25259

REGISTERED NO. E 25259

1-PLACE OF DEATH

City of BALTIMORE: (No. 2812 Belmont St., 16-6X Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Dorsey Railey

(a) RESIDENCE NO. 2812 Belmont St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Railey

6 DATE OF BIRTH (month, day, and year) December 4 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	25	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glazier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co

(State or country) Md

PARENTS

10 NAME OF FATHER Philip Railey

11 BIRTHPLACE OF FATHER (City or town)

(State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Mary D. Carleton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Mrs Lillian Railey

(Address) 2812 Belmont Ave

15 Filed SEP 4 1927 19 C. H. [illegible] Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/31 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to Aug 3, 1927, that I last saw h alive on Sept 2, 1927, and that death occurred, on the date stated above, at 9.2 m.

The CAUSE OF DEATH* was as follows: Acute Lymphatic Leukaemia

(duration) — yrs. 11 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Sept 3, 1927 (Address) 2712 Gwynns Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. Date of Burial SEP 10

20 UNDERTAKER Geo W Little ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25260

CERTIFICATE OF DEATH.

74-09 V E 25260

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins hosp St., 7-13 Ward)

2-FULL NAME Robert Schwartz

(a) RESIDENCE NO. 1609 E Eager St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14 1[illegible] 1917

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
10	11		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Max Schwartx

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Meltzer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Max Schwartz

(Address) 1609 E Eager St

15 Filed_____, 19_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Cause undetermined)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) History of Rheumatic heart. (duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

9/4/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Workmen Circle Cem Date of Burial 9/4 19

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25261

CERTIFICATE OF DEATH.

17 E 25261

1-PLACE OF DEATH St. Joseph's Hosp

CITY OF BALTIMORE: (No. 76-11 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Percy Stevenson.

(a) RESIDENCE NO. 3207 E. Monument ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Herrmann

6 DATE OF BIRTH (month, day, and year): 4/12/1884

7 AGE: Years 43 Months 4 Days 20. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Charles E. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Caroline Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Katherine Herrmann (Address) 3207 E. Monument St.

15 Filed Sept 4 19 27 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1927, to Sept 2, 1927, that I last saw h[illegible] alive on Sept 2, 1927, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Appendeceal abscess

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary): Toxemia

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 23-27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H Lawrence Fahnestock M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Sept 4 1927

20 UNDERTAKER: H. Sander & Sons — ADDRESS: 1710 Hoed Ave

Spec.—1-12-23—M&T—500 Blks.

E 25262 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

E 25262
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 N. Chapel ST. 8-17 WARD)

2-FULL NAME Ruth Doris Smith

(a) RESIDENCE No. 1806 N. Chapel ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 4 mos. 19 ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April-14-1927

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
—	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Ferdinan Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Evelyn Kraff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Evelyn Smith
(Address) 1806 N. Chapel St.

15 Filed ——, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1927, to Sept. 3 1927, that I last saw h alive on Sept. 3, 1927 and that death occurred, on the date stated above, at 7:20 P. M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis
Gastro-Enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frank H. Hunter, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Sept. 5 1927

20 UNDERTAKER: George W. Zinkler — ADDRESS: 1737 E. Eager St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25263

CERTIFICATE OF DEATH

31 ✓ E 25263

E 25263
1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 413 N Ann St. 69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellanora Jones

(a) RESIDENCE NO. 413 N Ann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race C

5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 2 1910

7 AGE Years 17 Months 3 Days 11

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Geo W Jones

11 BIRTHPLACE OF FATHER (City or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Edae MacCabe

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant [illegible]

(Address) 413 Ann St

15 Filed ..., 19 ...

Registrar RRL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1 1927 to Sept 2 1927

that I last saw her alive on Sept 2 1927

and that death occurred, on the date stated above, at 9 15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Phthisis Pulmonalis

(duration) yrs. 3 mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

Sept 3 1927 (Address) 508 Lamont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — Date of Burial Sept 5 1927

20 UNDERTAKER Robert V. Williams — ADDRESS 1515 McElderry St

Very important: Use typewriter or pen and ink. Do not use pencil. Be sure to answer every question.

[illegible] C. HANSON JONES, M. D.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25264

CERTIFICATE OF DEATH

129

REGISTERED NO. E 25264

1-PLACE OF DEATH

City of BALTIMORE: (No. Md Gen Hosp St. 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey B Kershaw

(a) RESIDENCE NO. 4228 Falls Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 7 mos. 28 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Kershaw

6 DATE OF BIRTH (month, day, and year) Jan 5 1882

7 AGE: Years 45 | Months 44 | Days 7 | 28 | IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse shoer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Kershaw

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER — Barnsley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ——

14 Informant Hospital Records

(Address)

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 9-3-27 4:00 PM, 19..., to 9-3-27, 19...,

that I last saw him alive on 9-3, 19 27,

and that death occurred, on the date stated above, at 7:40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

& hypertension

(duration) yrs. 10 known mos. ds.

CONTRIBUTORY (Secondary) Uremia ~~3 days~~ 1 wk

Cerebral Hemorrhage 5 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C C Hammerman, M. D.

. 19 (Address) 720 Osler Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial Sept 6 19 27

20 UNDERTAKER Wm Flickner Sons ADDRESS Hotel Md

Spec.—1-10-21—M&T—1500 Bks.

E 25265 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. E 25265

1-PLACE OF DEATH Nurses Court Apts

CITY OF BALTIMORE: (No. Apartment 12 L St. 563 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Sperry

(a) RESIDENCE NO. 30 Boyd ave. Jersey City, St., N.J. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward B. Sperry

6 DATE OF BIRTH (month, day, and year): May 15 1862

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
65	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brooklyn N.Y.

PARENTS

10 NAME OF FATHER: John Donahue

11 BIRTHPLACE OF FATHER (city or town) (State or country): Brooklyn N.Y.

12 MAIDEN NAME OF MOTHER: Anna Liston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calcutta India

Informant: Mrs. Mary E. Sperry

(Address) 30 Boyd ave Jersey City N.J.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1927, to Sept 3, 1927, that I last saw h[illegible] alive on Sept 2, 1927, and that death occurred, on the date stated above, at 6 H. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

9/3, 1927 (Address) 846 W 36th St. Phila.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arlington Cem. Arlington N.J. DATE OF BURIAL: Sept 6 1927

20 UNDERTAKER: W. J. Lickner & Sons ADDRESS: Penna Road ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25266

E 25266

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 W. 29th. ST. 12-51 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Linda Kelly

(a) RESIDENCE. No. 307 W. 29th ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Edward M. Kelly

6 DATE OF BIRTH (month, day, and year) June 25-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Jackson Fountain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Malinda Moffett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edward M. Kelly (Address) 307 W. 29th St.

15 Filed Sept 6 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 30 1927, to Sept 2 1927, that I last saw her alive on Sept 2 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

E Langston, M.D.

(duration) Final day mos. ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma

(duration) yrs. mos. Sudden ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Langston M.D.

Sept 6 1927 (Address) 112 W. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Sept. 6 1927

20 UNDERTAKER: Robt. T. Turner, Inc. — ADDRESS: 1447 N. Broadway

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25267

CERTIFICATE OF DEATH.

167-001

E 25267
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3908 Park Heights Ave. 15-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret D. Laker

(a) RESIDENCE NO. 3908 Park Heights Ave St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edwin H. Laker

6 DATE OF BIRTH (month, day, and year)
November 19, 1886

7 AGE 40 Years 41 Months 9 Days 13 14

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Long Island

(State or country) New York

PARENTS

10 NAME OF FATHER Edward Donoghue

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Delila Roche

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Miss Nellie Donohue

(Address) 1207 Eutaw Place

15 Filed SEP 4 1927 Baltimore, Md.

Registrar

Per KMC

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 2, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.)
find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abdominal Tumor
(Primary Surgical)

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary)

(duration) yrs. mos. ds.

(Signed) John H. Ehrman M. D.
(Coroner)

9/3, 192 7 (Address) 3632 Roland Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery Date of Burial 9/5/27 19

20 UNDERTAKER Joseph F. Cook ADDRESS 1003 W. Baltimore St

Spec.–7-17-26—A Co.—200 Bks.

E 25268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25268
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 208 Devonshire Drive Ward) 27-55-49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Plummer Waters Carr

(a) RESIDENCE NO. 208 Devonshire Drive St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angeline Carr

6 DATE OF BIRTH (month, day, and year) April 13, 1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Laurel
(State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Carr

11 BIRTHPLACE OF FATHER (City or town) Howard Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Waters

13 BIRTHPLACE OF MOTHER (city or town) A. A. Co.
(State or country) Maryland

14 Informant William E. Carr
(Address) 208 Devonshire Drive

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 2, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1927, to Sept 2, 1927, that I last saw him alive on Sept 2, 1927, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Operated 3 yrs ago

(Signed) Barrett Absalon, M. D.

9/7, 1927 (Address) 1404 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	9/5/27 19

20 UNDERTAKER Joseph Cook

ADDRESS 1003 W. Baltimore St.

Very Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25269

E 25269

91-002

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 420 S Washington St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Pinkowski

(a) RESIDENCE NO. 420 S Washington St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Pinkowski

6 DATE OF BIRTH (month, day, and year): March 25 1865

7 AGE — Years: 62 — Months: 5 — Days: 6 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Poland

PARENTS

10 NAME OF FATHER: Mikolaj Pyra

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Poland

14 Informant: Joseph Pinkowski

(Address): 420 S Washington St.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 1 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) Yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) Yrs. mos. 1 ds.

Sept 3/27 (Signed) G C Yates M. D. (Coroner)

(Address) 145 W 1 Eray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Date of Burial: Sept 5 1927

20 UNDERTAKER: John M Wilder ADDRESS: 1803 Bank St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25270

CERTIFICATE OF DEATH

90 E 25270

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2931 W.North Ave. St. 15-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E.Allen

(a) RESIDENCE NO. 2931 W.North Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 24 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles M.Allen

6 DATE OF BIRTH (month, day, and year) Jan.9 1857

7 AGE	Years	Months	Days 23	IF LESS than 1 day hrs. or min.
	70	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Emanuel Corbett

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Esther Watchman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Miss Ethel A.Allen

(Address) 2931 W.North Ave.

15 Filed 9-4-1927 19 E. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 2 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Sept 2, 1927

that I last saw h[illegible] alive on Sept 2, 1927

and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Corbett, M. D.

9/3/27 (Address) 2737 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Green Mount Cemetery	Sept 5 1927
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25271

CERTIFICATE OF DEATH.

28 E 25271

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1938 E Eagar ST. 1-13 WARD)

2-FULL NAME MICHAEL ANDRACK

(a) RESIDENCE No. 1938 E EAGAR ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. – mos. – ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): MARRIED

(If married, widowed, or divorced) HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1898

7 AGE 29 Years – Months – Days. If LESS than 1 day, hrs or min. About

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russian

PARENTS

10 NAME OF FATHER Unknown No.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russian

12 MAIDEN NAME OF MOTHER Unknown No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russian

14 Informant Andrus Swatoy

(Address) 1908 E Biddle Street

15 Filed ..... 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9–2 1927

17 I HEREBY CERTIFY, That I attended deceased from 9–1 1927 to 9–2 1927

that I last saw him alive on 9–1 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: a cute alcoholism

acute Nephritis

(duration) yrs mos 3 ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? findings

(Signed) J. Ruth Slaughter M. D.

(Address) 500 N Bell Ave

9–3–27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Russian Indepedet — DATE OF BURIAL: Sept. 5. 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S. Paca St.

Spec.–7-17-26—A Co.—200 Bks.

E25272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 25272

REGISTERED NO. 1925

1-PLACE OF DEATH

City of BALTIMORE: (No. Md Gen Hosp St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Vint

(a) RESIDENCE NO. 204 W. Franklin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Walter Lee Vint

6 DATE OF BIRTH (month, day, and year) Dec 6 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	50	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Bridgeport Pa
(State or country)

PARENTS

10 NAME OF FATHER Wm S Moore

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Connellsville Pa

12 MAIDEN NAME OF MOTHER Susan Morehouse

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Connellsville Pa

14 Informant Grace Vint
(Address) 204 W Franklin St

15 Filed ....., 19.... Registrar

C. HAMILTON JONES, M. D.
4 - 1927 Per RMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept 3 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/26/27, 1927, to 9/3/27, 1927, that I last saw h.e.r. alive on 9/3/27, 1927, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Primary carcinoma of spleen with metastasis to pancreas and liver

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted none

if not at place of death?

Did an operation precede death? yes Date of 8/6/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: 9/6 1927

20 UNDERTAKER: Chas. E. Crawford — ADDRESS: 1810 Royal Ave

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25273

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5226 York Road St. 27-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada May Utley

(a) RESIDENCE NO. 5226 York Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 24 1864

7 AGE: Years 62 Months 9 Days 10 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Penna

(State or country)

PARENTS

10 NAME OF FATHER Wm. Hawk

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Penna

12 MAIDEN NAME OF MOTHER Sarah Allison

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Penna.

14 Informant Clarence C. Utley

(Address) 3100 Denison St

15 Filed ... 19 ... Registrar RCK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Sept 3. 27

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1927, to Sept 3, 1927, that I last saw h[illegible] alive on Sept 3, 1927, and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver,
Metastasis ?

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Torsemia

(duration) yrs. 1 mos ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) S. W. Bishop, M. D.

Sept 4. 1927 (Address) 501 Thundene Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemy. Date of Burial: Sept 5, 1927

20 UNDERTAKER: John C. Mitchell & Sons ADDRESS 1914 Eutaw St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25274

CERTIFICATE OF DEATH.

188-003

E 25274

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Francis Christopher

(a) RESIDENCE NO. 28 Paul Court. Apt. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliz. A. Christopher

6 DATE OF BIRTH (month, day, and year): Dec. 15. 1888

7 AGE: Years 38 Months 8 Days 18 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bond

(b) General nature of industry, business, or establishment in which employed (or employer): Broker

(c) Name of employer

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER: James F. Christopher

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Clara A. Baldwin

13 BIRTHPLACE OF MOTHER (city or town): Del.

(State or country)

14 Informant: Eliz. A. Christopher

(Address) 3402 Clover Hill Road

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc.

Comp. Fract of Left. Leg

Septicemia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 0 ds.

(Signed) G. B. Yates M. D.

(Coroner) 9/7/27

(Address) 143 N. Bway

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Sept 5 1927

Date of Burial

20 UNDERTAKER: John O. Malehorn ADDRESS 1900 Eutaw Place

C. HAWSON JONES, M. D.

9-5-1927

Spec.—1-12-23—M&T—500 Blks.

E 25275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25275

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Lennox ST. 13-54 (WARD)

2-FULL NAME Daniel H. Sullivan

(a) RESIDENCE No. 716 Lennox ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elenora McNeil

6 DATE OF BIRTH (month, day, and year): Do not know

7 AGE — Years: 80 — Months: -- — Days: -- — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Plumber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Jeremiah Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Agnes Sullivan

(Address): 716 Lennox Street

15 Filed 9-1927, 19 C. HAMILTON JONES, M. D. By RLK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1927, to Sept 3, 1927, that I last saw him alive on Sept 3, 1927, and that death occurred, on the date stated above, at 8.20 P m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Ort. Nephritis & Arterio-Sclerosis (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam

(Signed) Wm. R. Straight M. D.

9/4, 1927 (Address) 2225 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 9/6, 1927

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 505 N Calvert

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25276

CERTIFICATE OF DEATH.

16-007

E 25276

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST) 1-3 (WARD)

2-FULL NAME Clement Meeniste

(a) RESIDENCE No. 617 S Milton ave. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced (b) HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Nov. 17 1926

8 AGE — Years | 9 Months | 14 Days | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

10 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Henry Meeniste

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ida Lyesniak.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 27. 1927. to Sept 3rd 1927. that I last saw him alive on Sept 3rd 1927 and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery, acute bacillary (Flexner variety)

(duration) (about) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home - 617 S Milton ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Stool examination

(Signed) A. L. MacLean, M. D.

, 19 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dist. Rosary Cemetery — DATE OF BURIAL: Sept 5 1927

20 UNDERTAKER: George E Weber — ADDRESS: 2205 Bank St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25277 · 23 E 25277

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 27-53

City of BALTIMORE: (No. ____ St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Francis L Dunham, MD

(a) RESIDENCE NO. 20 Merrymount Rd. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. ____ ds. How long in U. S. if of foreign birth? — yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth North Dunham

6 DATE OF BIRTH (month, day, and year) Oct 25, 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min..
	57	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor of Medicine

(b) General nature of industry, business, or establishment in which employed (or employer) Psychiatry

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Portland~~ Vermont

(State or country)

PARENTS

10 NAME OF FATHER George W. Dunham

11 BIRTHPLACE OF FATHER (City or town) Worcester

(State or country) Vermont

12 MAIDEN NAME OF MOTHER Martha Vail

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Vermont

14 Informant Patient

(Address)

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Sept 4, 1927, that I last saw h[illegible] alive on Sept 4, 1927, and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) ? yrs. ____ mos. ____ ds.

CONTRIBUTORY —

(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Frank K. Morris, M. D.

9/4, 1927 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston Mass — Date of Burial Sept 6 1927

20 UNDERTAKER Henry W Jenkins Son — ADDRESS [illegible]

Dec.—1-12-23—M&T—500 Bks.

Dr Morrissey 3632 Roland Ave

E 25278 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

E 25278

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2326 Barclay ST. 17-50 WARD)

2-FULL NAME Joseph L Conlin

(a) RESIDENCE No. 2326 Barclay ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6 If married, widowed, or divorced HUSBAND of or) WIFE of Mary A Conlin

7 DATE OF BIRTH (month, day, and year) Nov 19 1852

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer, Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N Y

10 NAME OF FATHER Joseph Conlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

PARENTS

14 Informant Mary A Conlin

(Address) 2326 Barclay St

15 Filed DEC 5 - 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1927, to Sept 2nd, 1927, that I last saw h~ alive on Sept 2nd, 1927, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

H. Colvert Morrissey jr

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Geo. W. Mumford III M. D.

9/3/1927 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem. | DATE OF BURIAL: Sept 5 1927

20 UNDERTAKER: Wm Cook | ADDRESS: 502 E Madison St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 25279
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 25279
REGISTERED NO.

City of BALTIMORE: (No. 1627 Jefferson St. 69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Slocum Jenkins

(a) RESIDENCE NO. 1627 Jefferson St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: Colored
5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Jenkins

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: Years 64 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Dress maker
(b) General nature of industry, business, or establishment in which employed (or employer): 069
(c) Name of employer

9 BIRTHPLACE (city or town): Balto Co
(State or country)

PARENTS

10 NAME OF FATHER: Benj Hughes
11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town): Unknown
(State or country)

14 Informant: Joseph Jenkins
(Address) 1627 Jefferson St

15 Filed ..... (19) ..... C. HERMAN JONES, M. D. Registrar
SEP 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1927, to Sept 2, 1927, that I last saw h.. alive on Sept 2, 1927, and that death occurred, on the date stated above, at 3 40 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Influenza (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Dr. Edward Fiske, M. D.

9-5-1927 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. Date of Burial: Sept 5 1927

20 UNDERTAKER: Mrs J. G. Locks ADDRESS: 1302 Jefferson

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25280

CERTIFICATE OF DEATH.

1927 E 25280

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward) 7331

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Knight.

(a) RESIDENCE NO. 903 Light St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ---------- How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	White.	Single.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John T. Knight.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Gregory.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant William C. Knight. (brother)

(Address) 2618 W. Franklin St.

15 Filed ....., 19.. .....Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 1, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest and autopsy. (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock due to 3rd degree burns about the body caused by having a burning lamp thrown on her. Homicide.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) (Coroner) M. D.

9/3, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs..mos.....ds. In the State.....yrs..mos.....ds.

Where was disease contracted, if not at place of death? 1012 Compton St. August 31, 1927.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 10/3 1927

20 UNDERTAKER William Cook ADDRESS 502 E. North Ave.

Spec.—1-12-23—M&T—560 Bks.

25281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

25281 E

129

13-5K

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810. Union Ave. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Ann. Boston.

(a) RESIDENCE No. 810 Union Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female.

4 COLOR OR RACE: white.

5 Single, Married, Widowed, or Divorced, (write the word): widow.

6a If married, widowed, or divorced (or) WIFE of Francis A. Boston.

6 DATE OF BIRTH (month, day, and year) Sept. 28/1838.

7 AGE — Years: 88. Months: 11. Days: 4. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: House work.

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Retired.

(c) Name of employer: at home.

9 BIRTHPLACE (city or town) (State or country): Eastern shore. Maryland.

PARENTS

10 NAME OF FATHER William Sanders.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown,

14 Informant: Mrs. Laura. V. Harford.

(Address) 810. Union, Ave.

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 25-th, 19 27, to Sept 2nd, 19 27, that I last saw h[illegible] alive on Sept 2nd, 19 27 and that death occurred, on the date stated above, at 11:00 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Nephritis. Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hyaline casts

(Signed) W. O. Fiscal M. D.

11/27 19.. (Address) 36 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery.

DATE OF BURIAL: Sept 5. 1927.

20 UNDERTAKER: J. Walter Davis.

ADDRESS: 3307 Paine St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25282

CERTIFICATE OF DEATH

E 25282

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2101 Linden ave St. 13 54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME SIMON RIEF

(a) RESIDENCE NO. 2101 Linden Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S. if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE: Years 63 Months — Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Realestate

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Rief

11 BIRTHPLACE OF FATHER (City or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Truma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rachel Rief

(Address) 2101 Linden Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to Sept, 1927, that I last saw h.. alive on Sept 4, 1927, and that death occurred, on the date stated above, at 8.45A m.

The CAUSE OF DEATH* was as follows:

Amyotrophi Lateral sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/4, 1927 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Date of Burial Sept 5 1927

20 UNDERTAKER Sol Levinson & Bro ADDRESS 1127 E Balto

SEP 5 - 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25283

CERTIFICATE OF DEATH

90 E 25283

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS 6946 REGISTERED NO.

City of BALTIMORE: (No. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gibbons

(a) RESIDENCE NO. 164 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 1, 1851

7 AGE: Years 75 Months 6 Days 2 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Nicholas Gibbons

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Barron

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant

(Address) [redacted]

15 Filed ..... 19.. Registrar

Per

SEP 5 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/3/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1927 to Sept. 3, 1927

that I last saw her alive on Sept. 3, 1927

and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic interstitial

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Sect

(Signed) C. Holmes Ogle, M. D.

19 (Address)

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — Date of Burial Sep 6, 1927

20 UNDERTAKER John A Moran — ADDRESS 3000 E Pratt

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25284

CERTIFICATE OF DEATH

67-001

E 25284

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1328 East Ave St., 1-V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Benjamin Tyler

(a) RESIDENCE NO. 132 S. East Ave St. ..... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. ... mos. ... ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lulu Rhoades

6 DATE OF BIRTH (month, day, and year) October 11-1878

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	48	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Talbott Co

(State or country) Md

PARENTS

10 NAME OF FATHER John Tyler

11 BIRTHPLACE OF FATHER (City or town) Talbott Co

(State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Md

14 Informant Mrs. Lulu Tyler

(Address) 132 S. East Ave

15 Filed SEP 5 - 1927 H. ... M. By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4-1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 27, to Sept 4, 19 27,

that I last saw h... alive on 9/4, 19 27,

and that death occurred, on the date stated above, at 12:50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

(duration) ... yrs. ... mos 1 hr. ds.

CONTRIBUTORY Auto Intoxication

(Secondary) Contus Colic

(duration) ... yrs. ... mos 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm A Linder M. D.

9/5, 19 27 (Address) 3023 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL— Mount Olivet Md — Date of Burial Sept 6 1927

20 UNDERTAKER John Mullins & Sons — ADDRESS 208 Essex

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25285
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

x 188-003

E 25285
REGISTERED NO.

City of BALTIMORE: (No. St. Joseph Hospital St., 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward J. Blakeley

(a) RESIDENCE NO. Baynesville, Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 Weeks yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Oct 2/1899

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	27	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Section Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer M & P R.R.

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Blakeley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Epig

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Albert Blakeley

(Address) Baynesville, Md

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Sept 2/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Spine (Collision of labor motor trucks on M & P R.R. about eight ago)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. F. Bowen M. D.
(Coroner)

9/5/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Providence Cemetery Date of Burial Sept 5 1927

20 UNDERTAKER Fred L. Cassard & Sons ADDRESS Fullerton

SEP 6 1927 HAYDEN JONES M.D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25286

REGISTERED NO. 179 E 25286

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. E-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward J. Raab

(a) RESIDENCE NO. 1001 N. Chapel St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) May 31/1925

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	2	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles A. Raab

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Co., Md

12 MAIDEN NAME OF MOTHER Anna F. Vanik

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Charles A. Raab

(Address)

15 Filed....., 19.. R.M.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd & 3rd burns over body.
Accidently fell into tub of hot water

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Wilson M. D.
(Coroner)

9/5/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Parkwood Cemetery Sept 6, 1927

20 UNDERTAKER ADDRESS

Pratt Lassahn Co. Fallston

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25287

CERTIFICATE OF DEATH

51

E 25287

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1723 Cole St., St. 14-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Jackson Elliott

(a) RESIDENCE NO. 1723 Cole St., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1920

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	7	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER James Elliott

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Olevia C. Cavey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant James Elliott.

(Address) 1723 Cole St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept. 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1927, to Sept 1st, 1927

that I last saw h~~im~~ alive on Sept 2nd, 1927

and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Ernest A. Sprout, M. D.

. 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

Date of Burial Sept 6 19

20 UNDERTAKER Harry N. Weitzel

ADDRESS 153 W. Lombard

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Basil Ariss

E 25288

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

CERTIFICATE OF DEATH.

E 25288
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mun Hosp — St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Basil Ariss

(a) RESIDENCE NO. 1826 McCulloh St Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 22. 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	23		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bell Boy

(b) General nature of industry, business, or establishment in which employed (or employer) Emerson Hotel

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Jamaica W. I.

PARENTS

10 NAME OF FATHER Albert Ariss.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Jam. W. I.

12 MAIDEN NAME OF MOTHER Julia Bayes.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Jam W. I.

14 Informant Owen Rodgers.

(Address) 1826 McCulloh St

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 1- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:* Acute A C

Fracture of Neck

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. ..... ds.

Sept 3 (Signed) Geo C. Weber M. D.

(Coroner)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial Sept 5 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 1303 Pressman St

E 1927 C. HUNSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25289 | CERTIFICATE OF DEATH. | 129 E 25289

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 Willow Street ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia T. Holmes

(a) RESIDENCE NO. 830 Willow ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael P. Holmes

6 DATE OF BIRTH (month, day, and year) July 31, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	61	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael McGherity

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Michael P. Holmes

(Address) 830 Willow St. Louis, M.

15 Filed 9-2-1927, 19 C. HAMPSON, M. D. Registrar

Per Rdc

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2-1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1927, to Sept 1, 1927, that I last saw h[illegible] alive on Sept 1, 1927, and that death occurred, on the date stated above, at 2.15 P.M.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) General arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. H. Hornstein M. D.

9/3, 1927 (Address) 733 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Sept. 6, 1927

20 UNDERTAKER Ida Wiedefeld — ADDRESS 914 Fremont Ave.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25290

CERTIFICATE OF DEATH

46 V

E 25290

REGISTERED NO.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 414 E 25th St 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Ward

(a) RESIDENCE NO. 414 E 25th St St. ..... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of J. Milton Ward

6 DATE OF BIRTH (month, day, and year) July 2nd 1873

7 AGE	Years	Months	Days
	54	1	13

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas H. King.

11 BIRTHPLACE OF FATHER (City or town) .....
(State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Estella Purnell

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Calvert Co. Md

14 Informant J. Milton Ward
(Address) 414 E. 25th St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 26th, 1927, to Sept 4th, 1927, that I last saw h[illegible] alive on Sept 4th, 1927, and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

..... (duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos ..... ds.

18 Where was disease contracted —

if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Geo W. Thompson M.D.

9/5/27 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cem	9/7 1927
20 UNDERTAKER	ADDRESS
E. Sehloman & Son	1084 Hanover St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25291

CERTIFICATE OF DEATH.

E 25291

1-PLACE OF DEATH

Registered No.

City of BALTIMORE; (No. 1930 McHenry St St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of John Fredk. and Mary G. Faller

(a) Residence No. 1930 McHenry St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 6½ hours How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write this word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept. 4-1927 10:30 P.M.

7-AGE. ... yrs. ... mos. ... ds.

If LESS than 1 day, 6 hrs. or 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS

10-NAME OF FATHER, John Fredk. Faller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER, Mary G. Colpine

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto, Md

14- (Informant) John F. Faller

(Address) 1930 McHenry St

15- Filed SEP 5 - 1927 Registrar. [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 5/1927.

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 (10:30 P.M.) 1927, to Sept 5 1927 (5 a.m.)

that I last saw her alive on Sept 5 1927,

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

of 7 mos. start

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. L. Mackall, M. D.

, 19 (Address) 130 S. Glenwood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL. Sept 5th 1927

UNDERTAKER, F. S. Wippert ADDRESS 150 N. Bond St

Spec.–7-17-26—A Co.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25292

CERTIFICATE OF DEATH

E 25292

1-PLACE OF DEATH

REGISTERED NO. 122-002 73-32

City of BALTIMORE: (No. 1818 E Charles St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida O Kamp

(a) RESIDENCE NO. 1818 E Charles St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm F Kamp

6 DATE OF BIRTH (month, day, and year) April 22 1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	73	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm Edward F Kamp (Address) 1932 E 28 st

15 Filed ..... 19 ..... Registrar RRK

C. HAMPTON JONES, M. D.
SEP 5 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to Sept 3, 1927

that I last saw her alive on Sept 3, 1927

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast Metastasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. E. K. Campbell M. D.

Sept 4, 1927 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Date of Burial Sept 6 1927

20 UNDERTAKER John F Denny ADDRESS 715 Light

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25293

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

167-001

E 25293

REGISTERED NO.

City of BALTIMORE: (No. 1111 Ward St. 9-1-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Greenwald

(a) RESIDENCE NO. 1111 Ward St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Unknown 1864

7 AGE: Years 63 Months — Days — IF LESS than 1 day.....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of indnstry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Mrs Amelia Zimmerman

(Address) 4119 Bedford Ave

15 Filed..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by Inquest and Autopsy find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Drowned by Jumping Illuminating Gas Dead when found

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Thos. E. Norton M. D.

Sept 4 1927 (Coroner)

(Address) Curtis Bay Md

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury; and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Weston Lawn Date of Burial: Sept 6 1927

20 UNDERTAKER: John J Cowan ADDRESS: 901 Hollins St

REGISTERED SEP 5 1927 CLARENCE R. MILLER M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25294

CERTIFICATE OF DEATH

90 E 25294

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1323 N. Montford Ave St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Krause

(a) RESIDENCE NO. 1323 N. Montford Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma D. Krause

6 DATE OF BIRTH (month, day, and year) Sept 23 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	71	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Molder 04?

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Theodore Krause

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Krause

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Emma D Krause

(Address) 1323 N Montford Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1927

17 I HEREBY CERTIFY, That I attended deceased from March 1 1927 to Sept 3 1927

that I last saw him alive on Sept 3 1927

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Gordy, M. D.

9-3 1927 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial 9/7 1927

20 UNDERTAKER Albert L Hilty Jr — ADDRESS 1606 N Chester St

KHJC

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25295

CERTIFICATE OF DEATH.

109-002

E 25295

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. St. Joseph Hospital St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fontaine McGuigan

(a) RESIDENCE NO. 1808 Aiken St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Dec 2/1925

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto., Md.

(State or country)

PARENTS

10 NAME OF FATHER B. McGuigan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Elizabeth Scarborough

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Harford Co., Md.

14 Informant B. McGuigan

(Address) 1808 Aiken St

15 Filed SEP 10 1927 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Sep 2/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to die death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Mitral Insufficiency

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Tonsillectomy (following)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Haller, M. D.

(Coroner)

9/5/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Margarets Cem Belair Rd

Date of Burial: 9 6 1927

20 UNDERTAKER: George J Ruth

ADDRESS: 1735 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25296

CERTIFICATE OF DEATH.

23 E 25296

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Colonial Hospital ST. 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Zeberlein

(a) RESIDENCE NO. 1836 Eastern Ave ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 3 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Zeberlein

6 DATE OF BIRTH (month, day, and year): May 4 1865

7 AGE — Years: 63 — Months: 3 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: Henry Zeberlein

9 BIRTHPLACE (city or town) (State or country): Baltimore md.

PARENTS

10 NAME OF FATHER: Chas Zeberlein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Henry Zeberlein 1836 Eastern Ave

15 Filed ... 19 ... Registrar: KAK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1927, to Sept 2, 1927, that I last saw h alive on Sept 2, 1927, and that death occurred, on the date stated above, at 11 02 A. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica (duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Pulmonary edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clin. data.

(Signed) Leo Schlenger, M. D.

, 19 (Address) 3034 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: Sept 6 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 1403 W North Ave

SEP 6 1927

Spec.–7-17-26—A Co.—200 Bks.

E 25297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

REGISTERED NO. E 25297

1-PLACE OF DEATH

City of BALTIMORE: (No. 3717 Sequoia Ave 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Bornscheuer.

(a) RESIDENCE NO. 3717 Sequoia Ave. 15 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S. if of foreign birth 56 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Wm Bornscheuer

6 DATE OF BIRTH (month, day, and year) Jan. 10th 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	77	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Hsd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Germany.

(State or country)

PARENTS

10 NAME OF FATHER Kalb.

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Zentgraf.

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Wm Bornscheuer Son

(Address) 3717 Sequoia Ave.

15 Filed ....., 19.... Registrar

C. HAMILTON JONES M.D. 1927 Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 1927, to Sept 4th 1927, that I last saw h alive on Sept 3rd 1927, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia.

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac + Respiratory Failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted Home

if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C Hamilton Jones, M. D.

. 19 (Address) 2802 Roslyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Matthias Cemetery	Sept 7th 1927

20 UNDERTAKER Lilly-Zeiler

ADDRESS 4035 Wyl

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25298
1-PLACE OF DEATH

129

E 25298
REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Wilson

(a) RESIDENCE NO. 2409 Arunde Ave. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. (If non-resident give city or town and State)
How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1862

7 AGE — Years: 65 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): ppl
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (City or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda ?

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant .....
(Address) Rear 2409 Arunde Ave.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1927 to Sept. 4, 1927, that I last saw him alive on Sept. 4, 1927, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
Arteriosclerosis
Hypertension
(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Gumeral & Symptoms.
(Signed) C. Howard Bruce, M. D.
19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Mt Auburn Cem Sept 6 - 1927

20 UNDERTAKER Daniel Earley
ADDRESS 916 Eutaw St.

Very important. See instructions on back of [illegible]

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25299

CERTIFICATE OF DEATH.

E 25299

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1402 Mt. Carmel St. WARD 20

2-FULL NAME Lucile Griffin

(a) RESIDENCE NO. 1402 Mt. Carmel St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE — Years: 43 — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. Carolina

PARENTS

10 NAME OF FATHER: M. V. Pope

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. Carolina

12 MAIDEN NAME OF MOTHER: E. M. Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. Carolina

14 Informant: M. V. Pope (Address): 1402 Mt. Carmel St.

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1927 to Sept 30, 1927 that I last saw h alive on Sept 30, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis M. D.

(Address) 527 Mad. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem

DATE OF BURIAL: Oct 10 1927

UNDERTAKER: Daniel Easton

ADDRESS 916 Eu ave

Spec.—1-10-21—M&T—1500 Bks.

E 25300 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 25300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No. 1711 Madison Ave., St. 14-20 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Preston

(a) RESIDENCE No. 1711 Madison Ave., ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jerry Preston

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	20	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Ben Rensburg

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary A. Smith

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Jerry Preston
(Address) 1711 Madison ave

15 Filed SEP 6 - 1927 HUGH S. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from August 30, 1927, to Sept. 3, 1927, that I last saw her alive on Sept. 4, 1927, and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) T.B. suspect

(duration) don't know yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. White, M. D.

, 19 (Address) 1029 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hosanna Mem Lutheran

DATE OF BURIAL Sept 6th 1927

20 UNDERTAKER Daniel Easton

ADDRESS 916 Ru we

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25301

CERTIFICATE OF DEATH

E 25301

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balty City Hospital St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Klingenberg

(a) RESIDENCE NO. Balto City Hospital St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 28/73

7 AGE: Years 53 Months 8 Days 6 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): md

(State or country)

PARENTS

10 NAME OF FATHER: Louis Klingenberg

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Ernestina Schmaal

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Ernestine Schmaal

(Address) 12 N. Belle Vista ave Roopsburg

15 Filed ..... 19 .....

Registrar

DEC 6 - 1927

Per RMK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

9-3-27

17 I HEREBY CERTIFY, That I attended deceased from 6-28- 19 27 to 9-3- 19 27

that I last saw h alive on 9-3- 19 27

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Primary)

(duration) Months

CONTRIBUTORY Terminal Bronchopneumonia

(Secondary)

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Cystoscopy & Autopsy

(Signed) Maxwell M. D.

19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lake Lawn — Date of Burial 9/6 19 27

20 UNDERTAKER: Phil J. Henry — ADDRESS 2016 Orleans St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25302

CERTIFICATE OF DEATH

91-002

E 25302
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1633 Ashland Av St. 9-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Ruppert

(a) RESIDENCE NO. 1633 Ashland Av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of late John Ruppert

6 DATE OF BIRTH (month, day, and year) Jan 25/42

7 AGE Years 85 Months 7 Days 8 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER John Kreutzer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Geo. L. Ruppert

(Address) 1633 Ashland Av

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3/27

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 19 27, to Sept 3rd 19 27

that I last saw her alive on Aug 30th 19 27

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Cause (duration) 4 days

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr W Feltner M. D.

Sept 4th 1927 (Address) 1501 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. Date of Burial: Sept. 6 19 27

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

25303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 25303

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2816 Elliott St. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Charles ~~Ellis~~ James

(a) RESIDENCE NO. 2816 Elliott St ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan 24, 1927

7 AGE: Years — Months 7 — Days 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Charles James

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Aida Roese

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pas Christian Miss.

14 Informant (Address): John James 2816 Elliott St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 4, 1927, to Sept 5, 1927, that I last saw her alive on Sept 4, 1927, and that death occurred, on the date stated above, at 12 05 A m.

The CAUSE OF DEATH* was as follows:

Marasmus - Malnutrition fever

acute diarrhoea

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. data

(Signed) Leo Eidlinger, M. D.

, 19 (Address) 3034 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Evergreen Cem

DATE OF BURIAL: Sep 6 1927

20 UNDERTAKER: Stephen L Fialkowski

ADDRESS: 1700 Edmondson

Spec.—1-12-23—M&T—500 Bks.

E 25304

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25304

CERTIFICATE OF DEATH.

REGISTERED NO. 90 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5106 Druyan Oak Ave (St.) 28-64 (WARD)

2-FULL NAME Anna Stewart Lewis.

(a) RESIDENCE No. 5106 Druyan Oak Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 26, 1880

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
47	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): 068

(c) Name of employer: Balto. Public Schools

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: George N. Lewis.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. George N. Lewis.

(Address) 5100 Druyan Oak Ave

15 Filed ..... 19 ..... Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1927, to Sept 4 1927.

that I last saw h alive on Sept 4 1927

and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

immediate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Stenosis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) A. C. Symmes M. D.

Sept 5 1927 (Address) 4509 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Sept 6 1927

20 UNDERTAKER: Wm J Reckner Sons — ADDRESS: North Ave

SEP 6 - 1927 C. H. JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25305
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

176 E 25305
REGISTERED NO.

City of BALTIMORE: (No. U. S. Marine Hospital St. 2331 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Mankins

(a) RESIDENCE NO. 1109 Race St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lucy Mankins

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Atlanta

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER George Mankins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Dorey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Self
(Address)

15 Filed ....., 19 .....
C. H. JONES, M. D.
9-1926
* Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death
on the day stated above.
The CAUSE OF DEATH was as follows:
Peritonitis General

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
(Coroner)

9/6, 1927 (Address) 3632 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Laurel Cemetery — Sept. 5, 1927

20 UNDERTAKER — ADDRESS
E. Leroy Stiffler — 1252 North Ave.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25306

CERTIFICATE OF DEATH.

54 E 25306

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2107 Christian ST. 20-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie C. Connolly

(a) RESIDENCE NO. 2107 Christian ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 22-1875.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57		11 12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: James Connolly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Emma McAdams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Connolly (Address) 2107 Christian

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-31, 1927, to 9-3, 1927 that I last saw her alive on 9-2, 1927 and that death occurred, on the date stated above, at 5. a. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Gastro Enteritis & Asthenia (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin, Findings

(Signed) James Connolly M. D.

19 (Address) Catonsville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Sept 1927

20 UNDERTAKER: Holt & Jones — ADDRESS: 1443 E Broadway

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25307 E 25307

CERTIFICATE OF DEATH.

100 001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 506 W. Lee St. 27-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Campbell

(a) Residence No. 506 W. Lee St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 9/4/27.

7-AGE. .....yrs. .....mos. .....ds. If LESS than 1 day, 15 hrs. or 20 min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore, Md
(State or Country).

PARENTS

10-NAME OF FATHER, Joseph Campbell

11-BIRTHPLACE OF FATHER (city or town) St. Mary's Co
(State or Country) Md.

12-MAIDEN NAME OF MOTHER, Sagrasa Campbell

13-BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or Country)

14-(Informant) Joseph Campbell
(Address) 506 W. Lee St.

15-Filed SEP 6 - 1927 THOMAS JONES, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/5/27

17- I HEREBY CERTIFY, That I attended deceased from 9/4 1927 to 9/5 1927
that I last saw h.. alive on 9/5 1927
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Atelectasis (congenital)

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Bronchial-pneumonia

(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Hebbetts M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn St. DATE OF BURIAL. Sept 6 - 1927

20-UNDERTAKER. L. E. Brown & Son ADDRESS 168 W. Mulberry St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25308

CERTIFICATE OF DEATH

E 25308

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3509 Windsor Mill Road St. 15-62 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina D. Hallowell

(a) RESIDENCE NO. Fedensburg, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
September 19, 1843

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	83	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dover

(State or country) Delaware

PARENTS

10 NAME OF FATHER Joseph Downham

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary James

13 BIRTHPLACE OF MOTHER (city or town) Kent Co.,

(State or country) Delaware

14 Informant Mrs. Wm. Ewin Bonn

(Address) 3509 Windsor Mill Rd.

15 Filed C 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 5, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec-5-, 1926, to Sept-5-, 1927, that I last saw her alive on Sept 3, 1927, and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Senile Myocardial Degeneration + Chronic Arthritis.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Age - 83+

(duration) yrs. mos. ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Haslup Cook, M.D.

9/6, 19 27 (Address) 2202 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fedensburg, Md.

Date of Burial 9/6/27 19

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 W. Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25309

58-001

CERTIFICATE OF DEATH.

E 25309
REGISTERED NO.

15-17

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis N. Klavans

(a) RESIDENCE NO. 2915 Ulman Avenue St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Klavans

6 DATE OF BIRTH (month, day, and year) Aug. 2nd, 1898

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	29	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER William Klavans

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Lena Ades

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant J. Lewis

(Address) 1439 E. Balto. St.

15 Filed ....., 19 ..... C. IRA PERSONS JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-5-1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Hemorrhage

Pernicious Anaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Culter, M. D.
(Coroner)

9/6/27 19 (Address) 508 E. Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Hebrew Rosedale 9/6 19 27

20 UNDERTAKER ADDRESS

Jack Levin 1439 E. Balto St

Cor.—12-9-25—A Co.—200 Bks.

E 25310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 E 25310

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinia Hospital St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Delson

(a) RESIDENCE NO. 2009 Bryant Ave., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) --------1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Shea Delson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Stera ------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Jos. Delson (Brother)

(Address) 3803 Belle Ave.

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 5- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombus

(Autopsy at Sinai Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Weller, M. D.

(Coroner)

9/6/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Mt Carmel Date of Burial 9/6 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25311

CERTIFICATE OF DEATH.

E 25311

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 S. Stricker ST., 19-27 WARD)

2-FULL NAME Viola A Basil

(a) RESIDENCE NO. 203 So. Stricker ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William L. Basil

6 DATE OF BIRTH (month, day, and year) Jan 8- 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	52	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William L. Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William L Basil

(Address) 203 S Stricker St

15 Filed ..... 19 ..... Registrar

(CHAS. JONES, M. D.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1927

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1927, to Sept 3, 1927.

that I last saw her alive on Sept 2, 1927,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease (Mitral Regurgitation

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) A Heller Hemming, M. D.

9/4, 1927 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park. DATE OF BURIAL Sept 6 1927

20 UNDERTAKER John J Fields ADDRESS 1200 W Fayette

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 25312

CERTIFICATE OF DEATH

41 ✓ E 25312

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1411 Linwood Hoyal St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Beatrice Trent

(a) RESIDENCE NO. 2414 Llewlyn St. Ward Balto Md.

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. 1 mos. 16 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Caucasian

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Albert Trent

6 DATE OF BIRTH (month, day, and year): July 18, 1900

7 AGE: Years 27 Months 1 Days 15 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town): Biddle St.

(State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William H Wimbrough

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Salisbury Md.

12 MAIDEN NAME OF MOTHER: Mary Mclean

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Baltimore Md.

14 Informant: Mrs Wm H. Wimbrough

(Address): 2464 Fremont ave Balto Md.

15 Filed....., 19..... Registrar

C. HUGHES, M. D.

6 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-1-27, 19..., to 9-3-27, 19..., that I last saw her alive on 9-3-27, 19..., and that death occurred, on the date stated above, at 2.20 p.m.

The CAUSE OF DEATH* was as follows:

Lineal Blood septicaemia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary): Accident of Lungs

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? at House

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical Picture

(Signed) [illegible], M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Sept 6 1927

20 UNDERTAKER: Horace F. Burgan — ADDRESS: 3631 Harford

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25313

CERTIFICATE OF DEATH

31 E 25313

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 431 N. Eden St. S. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Allen

(a) RESIDENCE NO. 431 N. Eden St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE: Years 43 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimd.

(State or country)

PARENTS

10 NAME OF FATHER Wm. Allen

11 BIRTHPLACE OF FATHER (City or town) Baltimd.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) Baltimd.

(State or country)

14 Informant Mamie Allen

(Address) 431 N. Eden St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 19 27

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1927, to Sept 4, 1927, that I last saw h[illegible] alive on Sept 4, 1927, and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tb Effusion and occasional Hemmorhage 2 wks.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) La Grippe and Acute Pulmonary Congestion

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) R. J. Young M. D.

9/6, 1927 (Address) 1429 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial Sept 7 1927

20 UNDERTAKER: Chas. H. Johnson — ADDRESS 1446 N. Carolina St.

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25314

CERTIFICATE OF DEATH

32 E 25314

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John McCrady

(a) RESIDENCE NO. 1535 E Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1912

7 AGE — Years: 15 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): at School

(c) Name of employer: S. C.

9 BIRTHPLACE (city or town) .....

(State or country): S. C.

PARENTS

10 NAME OF FATHER: John N. McCray

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country): S. C.

12 MAIDEN NAME OF MOTHER: Annie Hall

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country): S. C.

14 Informant: John N. McCray

(Address): 1535 E. Fayette St.

15 Filed SEP 6 - 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1927 to Sept 4, 1927, that I last saw h.er alive on Sept 3 1927, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Probably Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Sept. 1927 (Address) 508 Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial: Sept 6 1927

20 UNDERTAKER: Chas. N. Johnson — ADDRESS: 1610 N. Carolina Pl.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25315
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

43 E 25315
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 309 Augusta ST. 20-21 WARD)

2-FULL NAME Laura R Hamer

(a) RESIDENCE NO. 309 Augusta ST. 20 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs 7 mos 9 ds How long in U. S., if of foreign birth? yrs mos ds
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: W
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas Hamer

6 DATE OF BIRTH (month, day, and year): Jan 26-1876

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
51	7	9	8

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS
10 NAME OF FATHER: Louis Hamer
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto
12 MAIDEN NAME OF MOTHER: Laura Schaffer
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Mrs Chas Hamer 309 Augusta Ave

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to Sept 4, 1927, that I last saw h— alive on Sept 4, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of left breast

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 25-27

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Exam

(Signed) W. A. Krech, M. D.
(Address) Towson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Loan — DATE OF BURIAL: Sept 7th 1927

20 UNDERTAKER: John J Cowan & Son — ADDRESS: 901 Hollins St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25316

CERTIFICATE OF DEATH.

74-001

E 25316

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH 1838 E Lafayette Ave

City of BALTIMORE: (No. N.W. Cor Lafayette & Wolfe St. 17 Ward)

2-FULL NAME George W. Walker

(a) RESIDENCE NO. N.W. or Lafayette&Wolfe St._____ Ward_____
(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widwer

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Walker

6 DATE OF BIRTH (month, day, and year) June 5/1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of indnstry, business, or establishment in which employed (or employer) 659

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER George Walker

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) B

14 Informant Wm. Walker

(Address) [illegible]

15 Filed SEP 6 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 3/ 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ____ yrs. 5-6 mos. ____ ds.

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. F. H. Pollitz M. D.
(Coroner)

9/5/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial 9/6/1927

20 UNDERTAKER E. J. Fanning, Inc. ADDRESS 1386 Lafayette Ave.

Spec.—1-12-23—M&T—500 Blks.

E 25317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 25317

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1809 N. Washington ST. 8-17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth K. Wittmer

(a) RESIDENCE NO. 1809 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Henry Wittmer

6 DATE OF BIRTH (month, day, and year) May 6th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Miss Katherine Wittmer 1809 N. Washington St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1926, to Sept 3, 1927, that I last saw her alive on Sept 1, 1927 and that death occurred, on the date stated above, at 12.15 a. m.

The CAUSE OF DEATH* was as follows:

Arteria - Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 29 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert Harman, M. D.

(Address) 1216 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	9/6/1927

20 UNDERTAKER E. J. Fanning & Son ADDRESS 1386 Lafayette Ave

TION is very important. See instructions on reverse side.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25318

CERTIFICATE OF DEATH.

188-001

E 25318

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Univ Hospital St. (Ward) 24-34

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Foley

(a) RESIDENCE NO. 1517 Byrd St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hazel Jackson Fisher

6 DATE OF BIRTH (month, day and year): Oct. 7, 1898

7 AGE: Years 28 Months 10 Days 27 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B & O. R.R. Co

9 BIRTHPLACE (city or town):

(State or country): Frederick Co. Md.

PARENTS

10 NAME OF FATHER: George W. Fisher

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Mrs Hazel Jackson Fisher

(Address): 1517 Byrd St.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: F. F. (Trauma)

Fracture of Skull.

(Duration) Shock yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

Sept 4 27 (Signed) G. E. Pardo M. D.

(Coroner)

10 (Address) 143 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C. A. Co Date of Burial: Sept. 6 19 27

20 UNDERTAKER: Margaret E. Flynn ADDRESS: 1422 Light

Spec.—12-9-25—A Co.—200 Bks.

E 25319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143-003

E 25319 REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No.) St. 27-S Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alice Hogan

(a) RESIDENCE NO. 301 Spalding Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Hogan

6 DATE OF BIRTH (month, day, and year) July 10. 1892

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
35	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asstone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas not given Ryan

11 BIRTHPLACE OF FATHER (city or town) Dublin

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary L. Considine

13 BIRTHPLACE OF MOTHER (city or town) " "

(State or country) Md.

14 Informant Edward Hogan

(Address) 301 Spalding Ave

15 Filed ....., 19 ( ) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-5 1927

17

I HEREBY CERTIFY, That I attended deceased from 8-28 1927, to 9-5, 1927, that I last saw her alive on 9-5, 1927, and that death occurred, on the date stated above, at 1.35 a. m.

The CAUSE OF DEATH* was as follows:

Pernicious Vomiting of Pregnancy (duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Path.

(Signed) Francis L. Radcliffe M.D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Dan Cathedral Sept 1927

20 UNDERTAKER ADDRESS

H. Cook 502 E. North Ave

Spec.—1-12-23—MAT—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25320

CERTIFICATE OF DEATH

132 E 25320

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Broadway ST., 76-11 WARD)

2-FULL NAME Mrs Bertha Smith

(a) RESIDENCE NO. 3226 E Baltimore ST, ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. . mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of M. J. Smith

6 DATE OF BIRTH (month, day, and year) Feb 18, 1864

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
63	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER John Magsomen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant John E Smith
(Address) 3226 E Baltimore St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1927, to Sept 5, 1927, that I last saw h.. alive on Sept 5, 1927, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Uremia
Cystitis
Pyonephritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arteriol Sclerosis, bilateral

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George Brunn, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Sept 7 1927

20 UNDERTAKER: W. Cook — ADDRESS 502 E North Ave

Spec.—1-12-23—M&T—500 Bks.

E. Tritel

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25321

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

8-16 75-001

E 25321

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2301 E. Hoffman ST. 8-16 WARD)

2-FULL NAME Margaret A. Tritel

(a) RESIDENCE NO. 2301 E. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of or) WIFE of: Jeremiah H. Tritel

6 DATE OF BIRTH (month, day, and year): Aug. 29. 1839

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
88	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Conrad Tipple

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christine Togle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. C. Robinson

(Address) 2301 E. Hoffman St

15 Filed SEP 6 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1926, to Sept 4, 1927, that I last saw her alive on Sept 3, 1927, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Left Side).

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. F. Herzog M.D. M. D.

9/5, 1927 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: Sept 6 1927

20 UNDERTAKER: J. F. Cook

ADDRESS 502 E. Monument

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25322 31 E 25322

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) Balto City Hospitals (Ward) 16-22

2-FULL NAME Inez Hayne

(a) RESIDENCE NO. 632 N. Caroline St. Ward 8

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 13 yrs. 10 mos. 23 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: B.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 12 1914

7 AGE — Years: 12 Months: 10 Days: 23 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: Geo Hayne

11 BIRTHPLACE OF FATHER (City or town): Va.

(State or country)

12 MAIDEN NAME OF MOTHER: Mahoney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Hospital Records

(Address)

15 Filed ... 19 ... Registrar

SEP 5 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 29 19 27 to Sept 4 19 27

that I last saw h... alive on Sept 4 19 27

and that death occurred, on the date stated above, at 5.35 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

... years Duration (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY Tbc Enteritis, Tbc

(Secondary)

Enteritis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) H. E. Madden M. D.

19 27 (Address) Balto City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: Sept 6 19 27

20 UNDERTAKER: Wm H. Case Son — ADDRESS 1400 Harlem

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25323

CERTIFICATE OF DEATH

129 E 25323

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 2433 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Newman

(a) RESIDENCE NO. 132 E Gellingis St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1859

7 AGE — Years: 68 — Months: — Days: — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: James Newman

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Gillespie

13 BIRTHPLACE OF MOTHER (city or town): Canada

(State or country)

14 Informant: Mrs. Geo. Speigle

(Address) 400 Goodwood

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to Sept 4, 1927

that I last saw him alive on Sept 4, 1927

and that death occurred, on the date stated above, at 9:50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Chronic Myocarditis, Generalized Arteriosclerosis, Varicose Ulcers both legs (duration) last 3 years

CONTRIBUTORY (Secondary) Lobular Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. Blumer M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial 9/7 1927

20 UNDERTAKER: H. F. Kemp & Sons ADDRESS 1318 Eutaw Pl

Spec.—1-12-23—M&T—500 Bks.

14 06 15

14 25324

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 E 25324

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 1357 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Carter

(a) RESIDENCE No. 1503 Glenwood Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Robert Carter

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 38 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Ashley Downs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Molly Downs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19... Registrar ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 31st, 1927, to Sept 4, 1927, that I last saw h[illegible] alive on Sept 4, 1927, and that death occurred, on the date stated above, at 11:45 a m.

The CAUSE OF DEATH* was as follows:

- acute yellow atrophy, jaundice
- post-operative haemorrhage

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 3rd

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Raymond Wing M. D.

9/4/29 (Address) Johns Hopkins Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hyndeman DATE OF BURIAL: Sept 7, 1927

20 UNDERTAKER: Chenowith & Son ADDRESS: 1347 Chestnut

Spec. 7-17-26 A Co. 200 Bks.

E 25325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 25325

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 1521 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F. Thornton

(a) RESIDENCE NO. 1820 School St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Colored.

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Thornton

6 DATE OF BIRTH (month, day, and year): Unknown 1880

7 AGE: Years 47 Months Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stock Carrier

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Thornton

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Virginia

14 Informant: Baltimore City Hospt.

(Address)

15 Filed ..... 19 .....

C. E. [illegible]

Per R W C Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27: Sept. 2,

17 I HEREBY CERTIFY, That I attended deceased from August 2, 1927, to Sept 2, 1927

that I last saw him alive on Sept. 2, 1927

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis, Chronic myocarditis, Intestinal Stricture (Partially R.L.) Acute Uremia Retention (3 day duration) yrs Incontinence

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home (Car)

Did an operation precede death? yes Date of 9-30-27

Was there an autopsy? no

What test confirmed diagnosis? Physical Sign Only.

(Signed) M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemt. — Date of Burial: Sept 6, 1927

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1745 Washington Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25326

CERTIFICATE OF DEATH

E 25326

1-PLACE OF DEATH Balto City Hospts. 38

REGISTERED NO.

City of BALTIMORE: (No. Balto Md St. 24-35 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Stevenson

(a) RESIDENCE NO. 160 E Latrobe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Blk.

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lent Larue

6 DATE OF BIRTH (month, day, and year): Unknown 1883

7 AGE: Years 44 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Indiana

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospt

(Address) Balto Md

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept 3 - 1927

17

I HEREBY CERTIFY, That I attended deceased from July 22 19 27 to Sept 3 19 27

that I last saw her alive on Sept 3 19 27

and that death occurred, on the date stated above, at 2.40 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis w/ Cerebro Spinal Lues

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Serological & Clinical

(Signed) Phillip Pearlstein, M. D.

9/3, 1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial Sept 7 19 27

20 UNDERTAKER: Mrs R. G. Elliott ADDRESS 1425 Ashland Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25327

CERTIFICATE OF DEATH.

Caution

90 E 25327

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: Mills Fertilizer Factory St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aaron Pinder

(a) RESIDENCE NO. 1015 Hagues St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1881

7 AGE: Years 46; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Miller

(c) Name of employer: Fertilizer Factory

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Mary Pinder

(Address) 1015 Hagues St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1- 192 7

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Lawson Coroner M. D.

1/27 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary cem Date of Burial Sept 6 1927

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS 1725 Ashland av

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25328

CERTIFICATE OF DEATH.

182 E 25328

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (Co.) Gaston. Falls.- St. 16-68 (Ward)

2-FULL NAME James L Armstrong

(a) RESIDENCE NO. 1029 Bucktow St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 7-1860

7 AGE — Years: 66 — Months: 9 — Days: 29 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Armstrong

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)..... (State or country)

14 Informant Lillian Haschert (Address)

15 Filed ..... 1927 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows: Acc Drowning

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) ..... yrs. ..... mos. ..... ds.

Signed) G C Bladen M. D.

(Coroner)

(Address) 143 N B. way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Date of Burial 9-7-1927

20 UNDERTAKER Frank A. Cole ADDRESS 411 Hollins St.

Spec.—1-12-23—M&T—500 Blks.

E 25329

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25329

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 S. First ST. 76-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Cunningham

(a) RESIDENCE No. 1015 S. First ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 7-1927

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
—	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edw. C. Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Anna Bullock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Anna Cunningham

(Address) 1015 S. First St

15 Filed ..... 1927 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1927, to Sept 6, 1927, that I last saw her alive on Sept 6, 1927 and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronuskas, M. D.

9-6, 1927 (Address) 3037 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ochwatz Cemetery — DATE OF BURIAL: Sept 8 1927

20 UNDERTAKER: George N. Zickler — ADDRESS: 1737 E. Eager st

1927 (CHARLTON JONES, M.D.)

Spec.—1-12-23—M&T—500 Blks.

25330

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-081

E 25330

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3121 O'Donnell ST. 1-1 WARD)

2-FULL NAME William E. Mcabee

(a) RESIDENCE NO. 3121 O'Donnell ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. Mcabee

7 DATE OF BIRTH (month, day, and year) Oct. 11-1855

8 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	71	10	23	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Copper + Smelting Co.

10 BIRTHPLACE (city or town) (State or country) Laurel. Md.

PARENTS

10 NAME OF FATHER Thos. A. Mcabee.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co., Md.

12 MAIDEN NAME OF MOTHER Mary Wilkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Md.

14 Informant Laura V. Mcabee (Address 3121 O'Donnell St.

15 Filed ....., 19 .... A R H Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Sept 4, 1927, that I last saw h[illegible] alive on Sept 4, 1927 and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Francis Tilton, M. D.

9/5, 1927 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Sept 7 1927

20 UNDERTAKER George W. Zirkler ADDRESS 1737 E. Eager St

Spec.—1-12-23—M&T—500 Blks.

E 25331

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25331

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 675 W Barre ST.) 27-31 (WARD)

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josifin Firsuk

(a) RESIDENCE No. 675 W Barre ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11.1927

7 AGE Years 4 Months 24 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER J.Firsuk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russian

12 MAIDEN NAME OF MOTHER C.Senkus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvaina

14 Informant C.Firsuk

(Address) 675 W Barre Street

15 Filed ... , 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/2 .1927. to 9/5 .1927.

that I last saw her alive on 9/5 .1927

and that death occurred, on the date stated above, at 5 P M

The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) — yrs 1 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) David Drauckes M. D.

9/6 1927 (Address) 122 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept. 8. 1927

20 UNDERTAKER: John Grebliauckas & G. — ADDRESS: 423 S Paca St

Spec.–7-17-26—A Co.—200 Bks.

E 25332

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25332

1-PLACE OF DEATH

REGISTERED NO. 113

City of BALTIMORE: (No. 115 E. Gittings St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris E. Laduce.

(a) RESIDENCE NO. 115 E. Gittings. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 26 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Raee	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June, 10, 1927.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
		2,	26.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particeuler kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Julius Laduce.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie Vogel.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Carrie. Laduce.

(Address) 115 E. Gittings.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927 to Sept 5, 1927

that I last saw h alive on Sept 4, 1927

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at plaee of death?

Did an operation preeede death? No Date of

Was there an autopsy? No

What test eonfirmed diagnosis? Clinical

(Signed) H. E. Campbell M. D.

Sept 6, 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. Date of Burial Sept 7 1927

20 UNDERTAKER A. Howard Evans ADDRESS 38 E Fort Ave

1927

Spec.—1-10-21—M&T—1500 Bks.

E 25333

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25333

CERTIFICATE OF DEATH.

25-72 90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 Spring St., Morrell Park WARD)

2-FULL NAME Joseph Heinermann

(a) RESIDENCE No. 1232 Spring St. Morrell Park WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Barbara Heinermann 1869

6 DATE OF BIRTH (month, day, and year) Sept 12, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	57	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Retired for about 4 years.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria-Hungary

PARENTS

10 NAME OF FATHER George Heinerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria-Hungary

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria-Hungary

14 Informant Mrs. Barbara Heinermann
(Address) Morrell Park

15 Filed ..... 19 .....

1927 C. HANSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1927, to Sept. 4, 1927, that I last saw him alive on Sept. 4, 1927, and that death occurred, on the date stated above, at 7.55 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac thrombosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Senile myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. F. Townsend M. D.

Sept 6, 1927 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Sept 7 1927

20 UNDERTAKER Nelson E. Stiles

ADDRESS 231 Md. Ave Westport

Spec.—12-9-25—A Co.—200 Bks.

E 25334

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25334

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. German Aged & Home St. Baltimore and Payson Streets Ward 7-27)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy M. Robinson

(a) RESIDENCE NO. German Aged Home St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) April 15th. 1842

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
85	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Robinson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Janet Bunce

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant Records German Home

(Address) Balto. and Payson Sts.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6/27 19

17 I HEREBY CERTIFY, That I attended deceased from July 1927 to Sept. 6th, 1927, that I last saw him alive on Sept 5th, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis

(duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Senility

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

9/6, 1927 (Signed) John Neff, M. D.

(Address) 1142 W Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Sept. 8 19 27

20 UNDERTAKER Sept 8 B Cork ADDRESS 1003 W Balto St

Spec.—1-12-23—M&T—500 Bks.

E 25335

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) JOHNS HOPKINS HOSPITAL ST. (or WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Evans

(a) RESIDENCE NO. Aberdeen - Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) 3-17-27

7 AGE: Years 5 mos. Months 6 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bridie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records

(Address)

15 JOHNS HOPKINS HOSPITAL M. D.

Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1st, 1927, to Sept 6, 1927, that I last saw her alive on Sept. 5, 1927, and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Acute)

(duration) ... yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Allan Blossom, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Sept. 7 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

Spec.—1-12-23—M&T—500 Blks.

Dr Harber

E 25336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25336

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colgate P. O. Box 209 ST. 76-36 WARD)

2-FULL NAME Margaret Paul

(a) RESIDENCE NO. Colgate P. O. Box 209. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George W. Paul

6 DATE OF BIRTH (month, day, and year): May 7. 1863

7 AGE: Years 64 Months 3 Days 27 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Weis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothea Herbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14

Informant: George W. Paul

(Address) Colgate P. O.

15

Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1927

17

I HEREBY CERTIFY, That I attended deceased from June 15. 1927. to Sept 4. 1927.

that I last saw her alive on Sept 4. 1927.

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) None yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dawson L. Harber, M. D.

9/5/ 1927 (Address) Glarmis Pomona

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: Sept. 8 1927

20 UNDERTAKER: Henry Sander & Sons Inc

ADDRESS: 1910 Fleet St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25337

CERTIFICATE OF DEATH.

31 E 25337

1-PLACE OF DEATH 717 S. Potomac St

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1-1 WARD)

2-FULL NAME Hilda Marie Berends

(a) RESIDENCE NO. 717 S. Potomac ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	18	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frederick L. Berends

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Louise C. Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mother
(Address) 717 S. Potomac St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1927, to Sept. 8 1927, that I last saw her alive on Sept. 4 1927, and that death occurred, on the date stated above, at 9:20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. C. Dobihal M. D.

19 (Address) 477 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Paul's Cemetery — DATE OF BURIAL: Sept. 8 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

Spec.—1-12-23—M&T—500 Bks.

E 6222
E 25338

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25338

CERTIFICATE OF DEATH.

148

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

2-FULL NAME Helen Kedzor

(a) RESIDENCE No. 303 S. Ann ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Kedzor

6 DATE OF BIRTH (month, day, and year): 6-6-1905

7 AGE — Years: 22 — Months: — — Days: 27 — If LESS than 1 day, hrs. or ~~min.~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: — 39

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER John Urbanskie

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Lena Gutoskie

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar ASH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1927, to Sept 3, 1927, that I last saw h alive on Sept 3, 1927, and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary

(duration) ..... yrs. ..... mos 1 day ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) C H Peckham, M. D.

9-3, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rozary Sept

DATE OF BURIAL: 7 19 27

20 UNDERTAKER: John M Welch 1503

ADDRESS: Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25339

E 25339

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore Eye & Ear Hospital
1214 Eutaw Place

CITY OF BALTIMORE: (No.) S. 77-47 (Ward)

REGISTERED NO. 86

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Hatch

(a) RESIDENCE. No. 101 Chestnut Ave. St., Orrlea Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Mrs. Benjamin Hatch

6 DATE OF BIRTH (month, day, and year) Dec 15-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea Captain

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Merchants & Miners Transportation Co.

9 BIRTHPLACE (city or town) (State or country) Truro, Mass

PARENTS

10 NAME OF FATHER Samuel Hatch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Truro, Mass.

12 MAIDEN NAME OF MOTHER E. Childs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Truro, Mass.

14 Informant Mrs. Benjamin Hatch
(Address) 101 Chestnut Av - Orrlea

15 Filed ... 19... Registrar
File ... 0814

C. HARRISON JONES, M. D.
1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1927, to Sept 5, 1927, that I last saw him alive on Sept 5, 1927, and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis.

over

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Toxemia.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Sept 2, 1927

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Henry F. Gaff, M. D.

, 19 (Address) 1214 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Sept 8-'27
20 UNDERTAKER	ADDRESS
Frank E. Loats & Sons	Baltimore

Spec.–7-17-26—A Co.—200 Bks.

E 25340

HEALTH DEPARTMENT—CITY OF BALTIMORE

35 E 25340

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St., 6-11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Mack

(a) RESIDENCE NO. 111 N. Lakewood St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 2 mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE: Years 63 Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Carp. Helper

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Mary de Vries (Address) 111 N. Lakewood Ave.

15 Filed ..... 19 .....

1927 C. HAMPSON JONES, M. D. Registrar

Pro

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1927

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1927, to Sept 5, 1927, that I last saw him alive on Sept 5, 1927, and that death occurred, on the date stated above, at 3.05 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of rt hip.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) C. Holmes Bunge, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. Date of Burial 9/7 1927

20 UNDERTAKER: John G. Connelly ADDRESS Essex Md.

Spec.—1-12-23—M&T—500 Bks.

E 25341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 25341

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST. 8-17 (WARD)

2-FULL NAME Lulana Shoeberg

(a) RESIDENCE NO. 1637 N. Wolfe ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Bank 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Stallings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. L. Hamer

(Address) Baltimore P. O.

15 Filed , 19 1927 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5/27 19

17 I HEREBY CERTIFY, That I attended deceased from 9/2/27, 19, to 9/5/27, 19,

that I last saw her alive on 9/5/27, 19,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral embolus and senile dementia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lawrence Fahnestock M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 9/8/ 1927

20 UNDERTAKER John G. Connelly

ADDRESS Essex Md.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25342

CERTIFICATE OF DEATH.

E 25342

REGISTERED NO. 28163

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. ... WARD)

2-FULL NAME Barbara Sick

(a) RESIDENCE NO. Mount Hope Retreat ST., 25th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? [illegible] yrs. [illegible] mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Sick

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
Abt	50	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) (?) Germany

PARENTS

10 NAME OF FATHER Charles Koerner M D

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kunegunda Gertz

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Bavaria

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Balto Md.

15 Filed SEP 7 1927 19 RMC Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6. 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 18th, 1923, to Sept 6, 1927, that I last saw h.l. alive on Sept 6, 1927, and that death occurred, on the date stated above, at 2.50 a m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis & Senile Atheroma

abt 4 or 5 yrs (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Dementia

abt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Hamerr, M. D.

1927 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Sept 9 1927

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1201 E Eager St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25343

CERTIFICATE OF DEATH

E 25343

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General H St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Annie Flater

(a) RESIDENCE NO. Dundalk, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 16 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~

4 Color or Race White

5 Single, Married, Widowed, or Divorced ~~Married~~ Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Chas Fahey

6 DATE OF BIRTH (month, day, and year) 12-12-1859

7 AGE 67 Years 68 Months 8 Days 25 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H-W-

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER Elias Phillips

11 BIRTHPLACE OF FATHER (City or town) Carroll Co Md.

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Phillips

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Hosp. Records

(Address)

15 Filed ..... 19 .....

7-1927 C. HARRY ... M.D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7-27 19

17 I HEREBY CERTIFY, That I attended deceased from 7-21-27, 19..... to 9-7-27, 19.....

that I last saw h~~er~~ alive on 9-7-27, 19.....

and that death occurred, on the date stated above, at 2:05 A.m.

The CAUSE OF DEATH* was as follows: Carcinoma Uterus

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General cachexia

(duration) ? yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? Yes Date of June 26, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

19 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Sandy Mount Cemetery Md	Sept 9 1927
20 UNDERTAKER	ADDRESS
F Reese	Westminster Md

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25344

CERTIFICATE OF DEATH.

124 E 25344

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2731 E Monument St. (Ward) 7-10

2-FULL NAME James B Sanford

(a) RESIDENCE NO. 2731 E Monument St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Maria H Sanford

6 DATE OF BIRTH (month, day, and year): July 7 1861

7 AGE — Years: 66 — Months: 1 — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mariner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lancaster Co Va

PARENTS

10 NAME OF FATHER: James B Sanford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Caroline Thiod

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Mrs. J B. Sanford 2731 E Monument St

15 Filed ....., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5 1927

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1927, to Sept 5, 1927.

that I last saw him alive on Sept 5, 1927.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

6 (duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary): Chronic Int. Nephritis

(duration) 1 yrs. 1/2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm B Lemmon, M. D.

9/7/27 (Address) 718 N. Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Sept 8 1927

UNDERTAKER: W S Marshall — ADDRESS: 3539 Fait Rd

Spec. -7-17-26 —A Co.—200 Bks.

E 25345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 25345

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1535 Mceldery St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester A Parker

(a) RESIDENCE NO. 1535 Mceldery St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Parker

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House worke

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Jacob Berry

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Eliza Stepney

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Charles H. Parker

(Address) 1535 Mceldery st

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1927

I HEREBY CERTIFY, That I attended deceased from Septme 5 1927 to Sept 5 1927,

that I last saw her alive on Sept 5 1927,

and that death occurred, on the date stated above, at 10 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease

Chronic Myocarditis

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Sue Miller M. D.

Sept 6 1927 (Address) 708 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — Date of Burial Sept 9 1927

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans St

SEP 7 - 1927

M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25346

CERTIFICATE OF DEATH.

129 E 25346

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) Olivia & Caroline ST., (or) 8-13 WARD)

2-FULL NAME Mrs Annie Hagelgans

(a) RESIDENCE NO. 1106 Rutland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. P. Hagelgans.

6 DATE OF BIRTH (month, day, and year) June 17. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Moll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Peter Hagelgans

(Address) 1106 Rutland Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to Sept 6, 1927, that I last saw her alive on Sept 6, 1927, and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis. Nephritis C Hypertension.

Partial Intestinal obstruction?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ——

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) T. P. Thompson, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem — DATE OF BURIAL Sept 9 1927

20 UNDERTAKER John Ulrich — ADDRESS 2008 Orleans

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25347

CERTIFICATE OF DEATH

E 25347

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 15762

City of BALTIMORE: (No. ____ St. ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Williams

(a) RESIDENCE NO. 1385 Windsor Ave. St. ____ Ward ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE: Years 74 Months ____ Days ____ IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Servant
(b) General nature of Industry, business, or establishment in which employed (or employer) ____
(c) Name of employer ____

9 BIRTHPLACE (city or town) ____
(State or country) Va

PARENTS

10 NAME OF FATHER Henry Carter

11 BIRTHPLACE OF FATHER (City or town) ____
(State or country) Va

12 MAIDEN NAME OF MOTHER Jane ?

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant (Address) Hosp. Records.

15 Filed ____, 19 ____ Registrar ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept ____, 19 27, to Aug 14, 19 27, that I last saw h[er] alive on Aug 14, 19 27, and that death occurred, on the date stated above, at 8.40 A.M.

The CAUSE OF DEATH* was as follows:
Hardening of Arteries
Uremia
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted Home.
If not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____
(Signed) R. M. Magruder, M. D.
, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int. Auburn Cemetery — Date of Burial Sept 7 1927

20 UNDERTAKER Thomas E. Kelson — ADDRESS 130 Pleasant St

Very important. See instructions on back of this certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25348

CERTIFICATE OF DEATH

E 25348

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSP[illegible] St. 2423 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Evans

(a) RESIDENCE NO. 20 E. Wilkens St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/30/1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	58	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Burridge

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) [illegible]

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6/1927

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1927, to Sept 6, 1927, that I last saw h[illegible] alive on Sept 6, 1927 and that death occurred, on the date stated above, at 2:00 a. m.

The CAUSE OF DEATH* was as follows: myocardial insufficiency

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? P

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms

(Signed) C. Holmes Boyd, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Old Oakland M. E. Carroll Co. Date of Burial Sept 10 1927

20 UNDERTAKER W. Cook ADDRESS 207 E Monument

Very Important. See Instructions on back.

Spec.—1-12-23—M&T—500 Bks.

Mother Brought through

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25349

CERTIFICATE OF DEATH.

90 E 25349

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 200 S Baldwin ST. 26-7 WARD)

2-FULL NAME Dorothy E Gruenmel

(a) RESIDENCE NO. 200 S Baldwin ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22 1917

7 AGE — Years: 9 — Months: 8 — Days: 13 — If LESS than 1 day, hrs. or min.: 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas A Gruenmel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Wilhelm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Chas A Gruenmel 200 S Baldwin

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1927

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1927, to Sept 5, 1927, that I last saw h[illegible] alive on Sept 5, 1927 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Myocarditis

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) [illegible] M. D.

9/6, 1927 (Address) 301 Stillwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Sept 8 1927

DATE OF BURIAL

20 UNDERTAKER: H W Cole

ADDRESS 502 E Fayette

Spec.—1-12-23—M&T—500 Blks.

(Dr Raley M Brady)

HEALTH DEPARTMENT—CITY OF BALTIMORE

25350

CERTIFICATE OF DEATH.

89 E 25350

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 E North Ave 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Faulkner

(a) RESIDENCE NO. 419 E North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced, (write the word): Divorced

6a If ~~married, widowed,~~ or divorced HUSBAND of or ~~WIFE~~ of: Viola Faulkner

6 DATE OF BIRTH (month, day, and year): March 29 1879

7 AGE: Years 48 Months 5 Days 16

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: U. P. R. Co.

9 BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Richard Faulkner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Jesse D Taylor Orange New Jersey

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 26 1927 to Sept 5 1927

that I last saw him alive on Sept 4 1927

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Raley M. D.

Sept 6 1927 (Address) 1629 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kennedyville Md

DATE OF BURIAL: Sept 8 1927

UNDERTAKER: William Carson & Nathan

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25351

CERTIFICATE OF DEATH.

188-193

E 25351

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto Gen. St. 715-60

2-FULL NAME Giles B. Maddox

(a) RESIDENCE NO. 2812 West Lath St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) DEC. 20, 1918

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	8	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Gustava Maddox

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Amoa Gibbs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) U S

14 Informant C A Bryan

(Address) 2812 west Lathan

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) .....yrs. .....mos. ..... ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Sept 6, 1927 (Address) 1502 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Western Cemetery Sept 8 1927

20 UNDERTAKER — ADDRESS

Wm Cook 502 E Lath

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44

E 25352

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 25352

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 707 Mc Henry St 22-30 WARD)

2-FULL NAME John Decker

(a) RESIDENCE NO. 707 Mc Henry ST, ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	W	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen O Decker

6 DATE OF BIRTH (month, day, and year) Aug 1st 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .. min.
	78	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) cutg

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Decker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. H. Lutz

(Address) 707 Mc Henry st.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 1 1927, to Sept 6 1927, that I last saw him alive on Sept 6 1927 and that death occurred, on the date stated above, at 1 10 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Cl. & Phy Exam

(Signed) Fred T. Kyner, M. D.

, 19 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL Sept. 8th 1927

20 UNDERTAKER Humphrey Hammond & Co

ADDRESS 51 Edmondson

Cor.—12-9-25—A Co.—200 Bks.

E 25353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

186-003

E 25353

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mun Hospital St. 11-24 (Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry S-Agnew

(a) RESIDENCE NO. 1320 W. Cullo St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year) Nov 3=1900

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	17	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Elevator Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry Agnew

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Farrell

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant Annie Farrell

(Address) 1320 McCulloh

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Acc

Puncture of Intestines

(duration) ..... yrs ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Shock

Sept 6 (duration) ..... yrs ..... mos. ..... ds.

(Signed) J C Stadel M. D.

(Coroner)

(Address) 1430 Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Date of Burial Sept 7 1927

20 UNDERTAKER: Samuel T Hamburger ADDRESS 1430 Biddle

Spec.—12-25—A Co.—200 Bks.

E 25354

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25354

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Sinai Hosp. (Street) 9-7-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May Gilden

(a) RESIDENCE NO. 730 Oakley Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sadie

6 DATE OF BIRTH (month, day, and year): May 3/1889

7 AGE — Years: 38 — Months: 4 — Days: 4 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer): Soft Drinks

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Austria

PARENTS

10 NAME OF FATHER: Joseph Gilden

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Austria

12 MAIDEN NAME OF MOTHER: Sarah Land

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Austria

14 Informant: Sadie Gilden

(Address): 938 E Chase st

15 Filed 9-7-1927 C. HAMPSON JONES, M. D. Registrar

Per RHH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Sept 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Sept 6, 1927, that I last saw h.. alive on Sept 6, 1927, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Cardiovascular renal disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & physical exam.

(Signed) Morris J. Reckmeyer, M. D.

9-7, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial: 9/7 19 27

20 UNDERTAKER: Sol Levine & Bro — ADDRESS: E Balto st

Spec.—1-12 23—M&T—500 Blks.

25355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 16-002

REGISTERED No. E 25355

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Gardner

(a) RESIDENCE NO. Reisterstown Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-19-26

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1 Yr	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Molesworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rinaldi

(Address) JOHNS HOPKINS HOSPITAL

15 Filed — 19 — By — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 19 27

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 19 27, to Sept 6, 19 27, that I last saw him alive on Sept 6, 19 27, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary)

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia (?)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Macro. & Microscopic Exam.

(Signed) Allan Blackman, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union M. E. Cemetery

DATE OF BURIAL: Sept 8 1927

20 UNDERTAKER: Undertaker

ADDRESS: 6 E Main Reisterstown

JOHNS HOPKINS HOSPITAL ... STANTON JONES, M.D. ... 1927

Spec.–7-17-26—A Co.—200 Bks.

E 25356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25356

31

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals 10-69 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis N. Buhlman

(a) RESIDENCE NO. 2832 Frederick ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)
1875

7 AGE Years 52 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Buhlman

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Mary Dasch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
September 5, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 19 25 to September 5, 19 27
that I last saw him alive on September 5, 19 27
and that death occurred, on the date stated above, at 10.25 p. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tbc

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) L. L. Madden, M. D.
9-6-, 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Loudon Park 9/8/ 19 27

20 UNDERTAKER — ADDRESS
William Cook 5326 Nath Ave

Very Important. See instructions on back of Certificate.

9-1927 C. HAMPSON JONES, M. D.
Per ARW

Spec.-7-17-26—A Co.—200 Bks.

25357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 25357

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals S. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Moore

(a) RESIDENCE NO. 769 Dover st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days
	26		

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Walter Brown,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Rose ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospitel Records

(Address)

15 Filed ..... 19 .....

1827 C. HAMILTON JONES, M. D. Registrar

1682 morgan

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29, 1927. 19

17 I HEREBY CERTIFY, That I attended deceased from August 17 19 27, to August 29, 19 27,

that I last saw him alive on August 29, 19 27,

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Intraocular Hemorrhage

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary

Tuberculosis Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Laboratory

(Signed) L. E. Madden, M. D.

8-30-1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25358

CERTIFICATE OF DEATH

74-901

E 25358

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOS. 23-31 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Bunde.

(a) RESIDENCE NO. 209 Stenneken St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE — Years: 60(?) — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) [redacted]

15 Filed ....., 19.. Registrar

APP 1683

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/31/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar. 23, 1927, to Aug. 31, 1927

that I last saw him alive on Aug. 31, 1927

and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage -

Angina. Hemiplegia - Angina

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Hypertension (duration) ..... yrs. ? mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Family

(Signed) C. Wilmer Bunde, M. D.

, 19.. (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19..

20 UNDERTAKER — ADDRESS

Very Important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 25359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-08

E 25359

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Hohl

(a) RESIDENCE NO. 14 S. Caroline St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 72- Years Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer -

(b) General nature of industry, business, or establishment in which employed (or employer): O H D

(c) Name of employer

9 BIRTHPLACE (city or town): Germany -

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed , 19 Registrar

1684

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept 1 1927

17 I HEREBY CERTIFY, That I attended deceased from

6-18- , 1923 to 9-1- , 1927

that I last saw him alive on 9-1- , 1927

and that death occurred, on the date stated above, at 10:40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Generalized Edema 6

Acute Pneumonia,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Physical Signs

What test confirmed diagnosis?

(Signed) Jno Blizzard, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Very important. See instructions on back of certificate.

THE MORGUE

Spec.–7-17-26—A Co.—200 Bks.

E 25360

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25360

CERTIFICATE OF DEATH

129

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. [illegible] St., 4-6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Moore

(a) RESIDENCE NO. 98 E Pratt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divoreed, (write the word): Single

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 76 Years Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or partieular kind of work: Laborer

(b) General nature of industry, business, or establishment in whieh employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (eity or town) Scotland

(State or country)

PARENTS

10 NAME OF FATHER Dave Moore

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Sadie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address)

15 Filed 19

Registrar

1685

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3 1927

17

I HEREBY CERTIFY, That I attended deceased from 8-14, 1927, to 9-3, 1927, that I last saw him alive on 9-3, 1927, and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, acute

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis + Hypertention

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ,

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) C. Holmes Berryd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Very important. See instructions on back of this sheet.

Spec.—1-12-23—M&T—500 Bks.

(Getter)

E 25361 (E 25361)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25361

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Geller

(a) RESIDENCE NO. Fairmont W. Va. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Hanna Geller

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 58; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Henry Geller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Dansky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1927, to Sept 6, 1927, that I last saw him alive on Sept 6, 1927, and that death occurred, on the date stated above, at 4-30 p m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Morris Meyers M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Zanesville Ohio

DATE OF BURIAL: 9/7/27 19

20 UNDERTAKER: Joseph Ahrens

ADDRESS: 221 Bway

Spec.—1-12-23—M&T—500 Bks.

E 25362

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Standiford

(a) RESIDENCE NO. E. Fultonham, Ohio. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 30 Years — Months — Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Operator R. R.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER James Standiford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Ada Garrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1927, to Sept 7, 1927, that I last saw h alive on Sept 7, 1927, and that death occurred, on the date stated above, at 1.07 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, of brain stem

(duration) 1 yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 7, 1927

Was there an autopsy? Of head only

What test confirmed diagnosis? Operation

(Signed) R. Hooper Pleasants, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Zanesville Ohio

DATE OF BURIAL: 9/7/27

20 UNDERTAKER: Joseph Ahrens

ADDRESS: 221 Busy

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25363

CERTIFICATE OF DEATH.

E 25363

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 14 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Gray Cowan

(a) RESIDENCE NO. Norfolk, Va. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of xxxx

6 DATE OF BIRTH (month, day, and year) March 6/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	[redacted]	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Norfolk, Va.

PARENTS

10 NAME OF FATHER Beech Cowan

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) N.C.

12 MAIDEN NAME OF MOTHER Diana Cockey

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Va

14 Informant Beech Cowan

(Address) Norfolk, Va

15 Filed_____, 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 7/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Stricture of Duodenum

(Autopsy at Hopkins)

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Probable Pyloric + Intestinal (duration) ____ yrs. ____ mos. ____ ds.

(Signed) [signature] M. D.

(Coroner)

, 19 27 (Address) 556 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Date of Burial [illegible] 19 27

20 UNDERTAKER [illegible] ADDRESS 6326 [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25364 E 25364

CERTIFICATE OF DEATH.

REGISTERED NO. 21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1432 h. mount ST. (WARD) 15-21

2-FULL NAME Edith Martin

(a) RESIDENCE NO. 1432 h. mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Martin

6 DATE OF BIRTH (month, day, and year): Dec 15, 1857

7 AGE: Years 69 | Months 8 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co Maryland

PARENTS

10 NAME OF FATHER: Richard Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel Co. Maryland

12 MAIDEN NAME OF MOTHER: Margaritte Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co Maryland

14 Informant: John C. Martin

(Address) 1432 h. mount st

15 Filed [illegible], 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-5- 19 27

17 I HEREBY CERTIFY, That I attended deceased from 8-15 .1927. to 9-5 .1927

that I last saw her alive on 9-5 .1927.

and that death occurred, on the date stated above, at 9a. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) two yrs mos ds.

CONTRIBUTORY (Secondary): myocarditis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?: at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs & symptoms

(Signed) John C. C. Carpenter M. D.

19 (Address) 1405 h mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Town Neck Cem'y Md

DATE OF BURIAL: 9. 8. 1927

20 UNDERTAKER: E H Baker

ADDRESS: 27 Calvert Annapolis Md

E. HUNTSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 25365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25365

1-PLACE OF DEATH U. S. marine Hospital #1

CITY OF BALTIMORE: (No. Balt. Md. ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Aufort

(a) RESIDENCE No. 245 Wheeler Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident: give city or town and State) San Francisco Calif

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Lucian Aufort

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Steamer.

(c) Name of employer S/S Abangoka

9 BIRTHPLACE (city or town) (State or country) Calif.

PARENTS

10 NAME OF FATHER William Aufort

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Victoria Dubois

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant self

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Sept 6, 1927, that I last saw h— alive on Sept 6, 1927, and that death occurred, on the date stated above, at 12 530 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis Ruptured (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? S.S. Abangoka

Did an operation precede death? yes Date of Sept 3

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) C. H. Wilmuth M. D.

19 (Address) U. S. Marine Hospital #1 Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL ~~Interred~~ Buried in Saint Mary's, Hampden DATE OF BURIAL Sept. 8, 1927

20 UNDERTAKER E. Leroy Stiffler ADDRESS 1256 North Ave.

HAMILTON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25366 E 25366

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Patapsco Ave & 8th St. Brooklyn. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Lorenz.

(a) RESIDENCE NO. 1423 Lowman St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ---- How long in U. S., if of foreign birth? 18 yrs. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed or divorced HUSBAND of XXXXXXXXXX Stanislawa Lorenz.

6 DATE OF BIRTH (month, day, and year) December 5 1892.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34	8	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland.

PARENTS

10 NAME OF FATHER Teafil Lorenz.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Elemare Pupczyk.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland.

14 Informant Stanislawa Lorenz. (wife)

(Address) 1423 Lowman St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 4, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.

Thrown from a motor cycle, in collision with the rear of a moving Ford car.

Accidental death.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto H. Leuhardt M. D.

(Coroner)

9/7, 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Dept 6 Date of Burial 19 27

20 UNDERTAKER ADDRESS

J. Jos. McAleer 1803 Bank St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25367

CERTIFICATE OF DEATH.

E 25367

1-PLACE OF DEATH Sydenham Hospital

CITY OF BALTIMORE: (No. ST. 17-22 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Von White

(a) RESIDENCE NO. 848 Harlem Ave ST.. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 15 1922

7 AGE — Years: 4 Months: 8 Days: 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Dr. Jas A. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rockville N.C.

12 MAIDEN NAME OF MOTHER Mary S. Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wake, N.C.

14 Informant (Address) Dr. J.A. White 848 Harlem Ave

15 Filed SEP 8 1927 19 R.V.H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7- 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 1927 to Sept 7 1927, that I last saw h in alive on Sept 7 1927 and that death occurred, on the date stated above, at 2:50 A. m.

The CAUSE OF DEATH* was as follows:

Mastoid Disease

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Myron G. Tull M. D.

9/ 1927 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon DATE OF BURIAL 9/8 1927

20 UNDERTAKER Samuel Bendheim ADDRESS 578 Biddle

N. B.—W... matt... CAU... TION

SEP 8 1927 C. HAMBLETON M.D.

Cor.—12-9-25—A Co.—200 Bks.

E25368 HEALTH DEPARTMENT—CITY OF BALTIMORE E25368

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1123 Etting St. St. 17-34 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Brooks

(a) RESIDENCE NO. 1123 Etting St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet Brooks.

6 DATE OF BIRTH (month, day, and year) About 1860

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Home for Aged

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country)

14 Informant A. S. Eveleth

(Address) 719 Locust St.

15 Filed _____ 19 _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) _____ yrs. 2 mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. T. Ramsey M. D.

(Coroner)

Sept. 8 1927 (Address) 1512 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial 9/10 1927

20 UNDERTAKER Samuel Beasley ADDRESS 578 N. Eutaw

Very important that all questions be answered.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25369

CERTIFICATE OF DEATH.

102

E 25369
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 600 Sollers Road Govans St., 27-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Collison

(a) RESIDENCE NO. 600 Sollers Road St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William McD. Collison

6 DATE OF BIRTH (month, day, and year) April 30 1881

7 AGE	Years	Months	Days 6	IF LESS than 1 day ..... hrs. or ..... min.
	46	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Alexander Nelson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Trenton New Jersey

12 MAIDEN NAME OF MOTHER Anna Reed

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant William McD. Collison
(Address) 600 Sollers Road Govans

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17 Sept. 6/27

I HEREBY CERTIFY, That I attended deceased from Apr. 25 1927 to Sept 6 1927, that I last saw her alive on Sept. 5 1927, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Secondary Anaemia

(duration) 1 yr. mos. ds.

CONTRIBUTORY (secondary) Pleurisy, Dilated Heart

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Kregel, M. D.

9/7 1927 (Address) 1903 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Parkwood Cemetery Sept 8 1927

20 UNDERTAKER — ADDRESS

Chas. G. Black 742 W. North ave

SEP 8 - 1927 C. HAMPSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

E 25370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1192

E 25370

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St., 9-47 Ward)

2-FULL NAME Maude M. Unger

(a) RESIDENCE NO. 3933 Greenmount Ave., St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frederick W. Unger

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston,

(State or country) Pa.

PARENTS

10 NAME OF FATHER Samuel H. Snyder

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lewiston, Pa.

12 MAIDEN NAME OF MOTHER Sarah A. Lyter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mechanicsburg, Pa.

14 Informant Frederick W. Unger

(Address) 3933 Greenmount Ave.

15 Filed ..... 19 .....

SEP 8 - 1927

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base of Brain

Over Body

(Accidental Fall)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY

(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Monnier M. D.

(Coroner)

9/6. 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery Date of Burial Sept. 8 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Light

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25371 (1-PLACE OF DEATH)

E 25371 REGISTERED NO.

City of BALTIMORE: (No. 3115 Foster ave St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Tucker.

(a) RESIDENCE NO. 3115 Foster ave St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. da. How long in U. S. if of foreign birth 56 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary K. Tucker.

6 DATE OF BIRTH (month, day, and year) July 6 1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker.

(b) General nature of industry, business, or establishment in which employed (or employer) C.M.

(c) Name of employer

9 BIRTHPLACE (city or town) Germany.

(State or country)

PARENTS

10 NAME OF FATHER John Tucker.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Ely

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary K. Tucker.

(Address) 3115 Foster ave.

15 Filed SEP 8 - 1927 19 Registrar R.F.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1927, to Sept. 6, 1927.

that I last saw him alive on Sept. 5 1927.

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

Not definite - Prob. 6 or 7 months (duration) yrs. mos. da.

CONTRIBUTORY Exhaustion

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. N. Hayden, M. D.

9/8/1927 (Address) 1216 N. Carolina st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer Cem.	Sept. 10 1927
20 UNDERTAKER	ADDRESS
Lilly + Geiler	433 S. Wolfe st

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25372

CERTIFICATE OF DEATH.

74-001

E 25372

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1020 N. Gay 21-29 (Ward)

2-FULL NAME Richard T. Barfield

(a) RESIDENCE NO. 1020 N. Gay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 17th 1847

7 AGE: Years 80 Months 6 Days 20

IF LESS than 1 day.....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Chas. Barfield

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Sallie Smith

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant (Address): Nellie Barfield 1020 N. Gay St

15 Filed Sept 6 1927 19 [illegible], Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 6th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.), thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Apoplexy

(duration) at once

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed Thos. B. Horton (Coroner)

Sept 7 1927 Address Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: Sept 9 1927

20 UNDERTAKER: George J. Smith — ADDRESS 1512 Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25373 CERTIFICATE OF DEATH

124 25373

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 340 W Biddle ST. 11-24 WARD)

2-FULL NAME Charles Covington

(a) RESIDENCE NO. 340 W Biddle ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Covington

6 DATE OF BIRTH (month, day, and year): May 10 1860

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Charles Covington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Anita West
(Address) 2508 McCulloh St

15 Filed SEP 6 1927 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Sept 5, 1927, that I last saw him alive on Sept 4, 1927, and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema &
Interstitial Nephritis Chronic

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis & Arteriosclerosis (duration) 2 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm A. Wright M. D.

(Address) 1209 Presbman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery — DATE OF BURIAL: Sept 8, 1927

20 UNDERTAKER: Mrs. Kate R. Williams — ADDRESS 312 N. Schroeder St

SEP 6 - 1927 HARRISON JONES, M. D.

Spec.—8-24-14—M. & T.—2000 Blks.

E 25374 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25374

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Homewood Ave St.; 9-18 WARD) 108

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida May Lindsay

(Residence in Baltimore: No. 1303 Homewood Ave St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 22 (Day), 1879 (Year)

7-AGE, 48 yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Union Bridge Md.

PARENTS.

10-NAME OF FATHER, Hiram B Jones

11-BIRTHPLACE OF FATHER (State or Country), Union Bridge Md

12-MAIDEN NAME OF MOTHER Molly Esterline

13-BIRTHPLACE OF MOTHER (State or Country), Thurmont Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm A Lindsay

(Address) 1303 Homewood Ave

15-

Filed ....., 191.... Registrar.

C. HAMPSON JONES, M. D.

SEP 8 - 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 6th (Month) (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 1927, to Sept 6th 1927, that I saw h er alive on Sept 6th 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Asthenia

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Pyorrhea

(Duration) 2 yrs. ....mos. ....ds.

(Signed) Wm P Quay M. D.

Sept 6, 1927 (Address) 1 Park & Preston Sts.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Prospect Hill Union Bridge Md DATE OF BURIAL, Sept 9, 1927

20-UNDERTAKER Edward A Fink ADDRESS 734 Poplar Grove St.

E 25375

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25375

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 4210 Walnut Ave ST. 28-66 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Euker

(a) RESIDENCE. No. 4210 Walnut Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Euker

6 DATE OF BIRTH (month, day, and year): Apr. 24 1882

7 AGE: Years 45 Months 4 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: X Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James W. Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Josephine Boswell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Chas A. Euker 4210 Walnut Ave

15 Filed 8-1927 19 Registrar C. HAMPSON JONES

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year): Sept. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from June 30 1927 to Sept. 7 1927 that I last saw her alive on Sept. 7 1927 and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxaemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? yes Date of Jan. 8. '27

Was there an autopsy? no

What test confirmed diagnosis? Path. Laboratory Report.

(Signed) Lantus I. Jaggott M. D.

, 19 (Address) 1015 Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park DATE OF BURIAL: Sept. 9 1927

20 UNDERTAKER: John O. Mitchell ADDRESS: 1900 Eutaw Pl.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 25376 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12/9 E 25376

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1323 W Lafayette Av St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Warfield Joyner

(a) Residence No. 1323 W Lafayette Av St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.)
Female	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Algie Joyner

6-DATE OF BIRTH (month, day and year) Feby 2-1883

7-AGE.	If LESS than 1 day.
44 yrs. 7 mos. 5 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Private Cook

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Charles W Warfield

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Florence Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-

(Informant) Mamie Joyner

(Address) 1323 W Lafayette Av

15-

Filed ..... 192 ..... Registrar.

8-1927 C. HANSON JONES, M. D. RKK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 7-1927

17- I HEREBY CERTIFY, That I attended deceased from July 7th, 1927, to Sept 7th, 1927, that I last saw her alive on Sept 4th, 1927, and that death occurred, on the date stated above, at 1.15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) — yrs. 2 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination & Symptoms

(Signed) Edward Ellsworth, M. D.

Sept 8, 1927 (Address) 1330 N North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	9/9/1927

20-UNDERTAKER. Wm Geo H. Holland ADDRESS 163 Druid Hill

Spec.—1-12-23—M&T—500 Bks.

Dr Hemmeter 3012 Garrison Ave

E 25377 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

M 1001 ✓ E 25377

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1031 Brantley Ave ST., 16-7th WARD)

2-FULL NAME Emma J Schaefer

(a) RESIDENCE NO. 1031 Brantley Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Schaefer

6 DATE OF BIRTH (month, day, and year) Oct 10, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	76	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Louis Schaefer
(Address) 1031 Brantley Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 27, to Sept 7, 19 27, that I last saw h[illegible] alive on Sept 1, 19 27 and that death occurred, on the date stated above, at 2.45 pm

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. Hemmeter, M. D.

Sept 7, 19 27 (Address) 3002 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville — DATE OF BURIAL Sept 9 19 27

20 UNDERTAKER Wm. Cook — ADDRESS 901 E Monument

Spec.—7-17-26—A Co.—200 Bks.

E 25378

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25378

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1 Valley View ave St. No. 76-41 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Samm

(a) RESIDENCE NO. 1 Valley View ave Ward 26
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S. if of foreign birth 73 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: of Victor

6 DATE OF BIRTH (month, day, and year): Sept 1 1838

7 AGE — Years: 89 Months: 7 Days:

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Germany

PARENTS

10 NAME OF FATHER: Louis Fast

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Elenor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Germany

14 Informant: Catherine Pearson
(Address): 1 Valley View Ave

15 Filed ..... 19 .....

SEP 8 - 1927

Per RRK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Sept 8, 1927, that I last saw her alive on Sept 7, 1927, and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows:

(a) Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. F. Watkinson, M. D.

9/8/1927. (Address) Raspeburg Sta., Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem't — Date of Burial: Sept 10 1927

20 UNDERTAKER: William Cadsow — ADDRESS: E North ave

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25379
1-PLACE OF DEATH

REGISTERED NO. E 25379

City of BALTIMORE: (No. 111 Gen Hosp 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Edward Weed

(a) RESIDENCE NO. 1111 Parkway & 39th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Genevieve Woolsey

6 DATE OF BIRTH (month, day, and year) Jan 13 1885

7 AGE	Years	Months	Days
	42	7	24

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work civil engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Baker Asphalt Co

(c) Name of employer

9 BIRTHPLACE (city or town) Troy N.Y.

(State or country)

PARENTS

10 NAME OF FATHER John Weed

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ~~China~~ New York

12 MAIDEN NAME OF MOTHER Louise Bluckrose

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York

14 Informant Mrs C E Weed

(Address) University Pkwy & 39th St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1927 19

17 I HEREBY CERTIFY, That I attended deceased from noon 9/6 19 27 to 7.35 9/6 19 27, that I last saw h.. alive on 9/6 19 27, and that death occurred, on the date stated above, at 7.35 P m.

The CAUSE OF DEATH* was as follows:

(Ruptured) appendicitis

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) generalized peritonitis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 9/6/27

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) C. Hampson Jones M. D.

9/6/27 19 (Address) 1111 Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Troy N.Y.

Date of Burial Sept 9 1927

20 UNDERTAKER H. H. Cook

ADDRESS 502 Shaw Ave

very important. See instructions on back of certificates.

9 - 1927 C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25380 101-001 E 25380

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (C.H.) St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerry [redacted] Banks

(a) RESIDENCE NO. 202 S. Dallas st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Reuben Taylor

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Scott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from August 30 19 27 to September 4 19 27

that I last saw h[illegible] alive on in September 4 19 27

and that death occurred, on the date stated above, at 5.35 A. M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. E. Maddox M. D.

9-5-. 1927 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery Date of Burial Sept 8 1927

20 UNDERTAKER Wendell J. Lipsitt ADDRESS 3700 Eden

Very important. See instructions on back of certificates.

8-1927 C. HUDSON JONES, M. D.

NRR

Spec.–7-17-26—A Co.—200 Bks.

E 25381

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 25381

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 1829 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benden Lewis

(a) RESIDENCE NO. 1205 W. Baltimore Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE — Years: 54 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Virginia

PARENTS

10 NAME OF FATHER Sam Lewis

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Nancy ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Virginia

14 Informant:

(Address) BALTIMORE CITY HOSPITALS

15 Filed ....., 19 .. C. HAMPSON JONES, M. D.

9 - 1927 Par 1690 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5/ 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to Sept. 5, 1927

that I last saw him alive on Sept. 5, 1927

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Arteriosclerosis

Hypertension

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General + Sect.

(Signed) C. Hampson Jones, M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 25382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 25382

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St., 9-14 Ward)

BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Carroll

(a) RESIDENCE NO. None given (105 E. Lafayette) St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 60 (?) Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D.C.

(State or country)

PARENTS

10 NAME OF FATHER Patrick Carroll

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Flynn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dist of Columbia

14 Informant Hosp Records

(Address)

15 Filed [illegible], 19 [illegible] Registrar

RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 6 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-23, 1927, to 9-6, 1927, that I last saw h[illegible] alive on 9-6, 1927, and that death occurred, on the date stated above, at 6 00 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis and Insufficiency

(duration) ? yrs. mos. ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys findings.

(Signed) C. Herbert Boyd, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

Date of Burial 9/9 1927

20 UNDERTAKER J. J. Daley & Son

ADDRESS 13 N. Eighty St.

very important. See instructions on back of certificate.

Spec.–7-17-26–A Co.—200 Bks.

E 25383

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25383

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

City of BALTIMORE: No. BALTIMORE CITY HOSPITALS St. 8-13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah J. Hall

(a) RESIDENCE NO. 1931 E. Biddle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) – – 1867

7 AGE 60 Years Months Days IF LESS than I day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant Asst. Physician

(Address)

15 Filed 8-1927 19 C. HAMILTON JONES, M. D. Registrar

Per MH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7, 1927, to 9-2, 1927, that I last saw h[illegible] alive on 9-2, 1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute & Chronic myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertention

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. findings

(Signed) C. Hamilton Jones, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Date of Burial 9/8 1927

20 UNDERTAKER J J Fahey Sons ADDRESS 1318 Light

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 25384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25384

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. I4 Hamilton Ave., St. 27-43 Ward)

2-FULL NAME Elizabeth Miller (Deichmiller)

(a) RESIDENCE NO. I4 Hamilton Ave., St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3, I865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	62	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Artist

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Peter Deichmiller

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Wolf

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Dorathea Deichmiller

(Address) I4 Hamilton Ave.

15 Filed , I9 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6/27

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Sept 6, 1927

that I last saw h Ex alive on Sept 6, 1927

and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas Keller, M. D.

, I9 (Address) 502 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial Sept 9 1927

20 UNDERTAKER Harry H Wright

ADDRESS 1531 W Lombard

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25385

CERTIFICATE OF DEATH.

90 ✓ **E 25385**

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karl Selysem

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3, 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Austria Hungary

PARENTS

10 NAME OF FATHER Karl Selysem

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Rose Spilka

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St

15 Filed.....19..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept 4 1927, to Sept 7 1927,

that I last saw h.. alive on Sept 4, 1927,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Sept 8, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Cathedral Sept 10. 1927

20 UNDERTAKER — ADDRESS

Rita Wiedefeld 914 Fremont Ave

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 25386

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25386

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Schaffer.

(a) RESIDENCE NO. 821 S. Emmard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Schaefer

6 DATE OF BIRTH (month, day, and year) Feb. 28 1856.

7 AGE Years 71 Months 6 Days 7 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER John Schaffer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Louise ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant BALTIMORE CITY HOSPITALS

(Address)

15 Filed ....., 19 ..... Registrar AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1927 to Sept. 5, 1927

that I last saw him alive on Sept. 5, 1927

and that death occurred, on the date stated above, at 6:35 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic.

Arteriosclerosis.

Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Gross & Sec

(Signed) C. Hudson Jones, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Cemetery

Date of Burial Sept 9 1927

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

(Guglielmi)

E 25387

HEALTH DEPARTMENT—CITY OF BALTIMORE

34

E 25387

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. .....

City of BALTIMORE: (No. Balto City Hospital St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Guglielmi

(a) RESIDENCE NO. 2719 Atkinson St. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S. if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 59 (Years / Months / Days)

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER Luigi Guglielmi

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Rosell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Rachel Guglielmi

(Address) 5-32 S Paca St.

15 Filed ....., 19.. C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5- 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-23, 1927, to 9-6-, 1927 that I last saw her alive on 9-5-, 1927 and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Colitis Disease 7th Dorsal Vertebra

(duration) 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Meningitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Physical Exam

(Signed) H. Blizzard, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer. Date of Burial 9/9 1927

20 UNDERTAKER: John Grebbenstein ADDRESS 423 Naud

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25388 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25388

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3929 Keswick Road ST. 12-49 WARD)

2-FULL NAME Minnie M. McCoy

(a) RESIDENCE NO. 3929 Keswick Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles D. McCoy

6 DATE OF BIRTH (month, day, and year) -------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER George Taylor Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary McDonough

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Chas. C. Bradley (Address) 3929 Keswick Road

15 Filed 1927, 19 NRA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 - 1927

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1927, to Sept-8, 1927, that I last saw her alive on Sept-7, 1927, and that death occurred, on the date stated above, at 1-48 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Mitral Regurgitation

(duration) yrs. 5 mos 21 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) M. Tilson Porter, M. D.

9/8, 1927 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Staunton, Virginia

DATE OF BURIAL 9/ 19 27

20 UNDERTAKER Henry W. Myers & Son

ADDRESS 805 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

E 25389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25389

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 Wilkens Ave ST., W-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Louise Knauff,

(a) RESIDENCE NO. 1932 Wilkens Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard A Knauff

6 DATE OF BIRTH (month, day, and year): January 16, 1848

7 AGE — Years: 79 — Months: 7 — Days: 21 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Frederick, Md.

PARENTS

10 NAME OF FATHER: Wm. Dixon,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick, Md

12 MAIDEN NAME OF MOTHER: Rebecca Stallings

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick,

14 Informant: Mrs. Cathryn Knauff

(Address): 1932 Wilkens Ave

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 7, 1927

17

I HEREBY CERTIFY, That I attended deceased from September 3, 1927, to Sept 7, 1927, that I last saw her alive on Sept. 3, 1927, and that death occurred, on the date stated above, at 5:57 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, 1

Duration 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene

Duration yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical-Urine

(Signed) Wm. A. Stevenson M. D.

9/8, 1927 (Address) 1201 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: 9-8 1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Calhoun Hollins Sts

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25390

CERTIFICATE OF DEATH

49

E 25390

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1430 Jackson St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John O. McFarland

(a) RESIDENCE NO. 1430 Jackson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine McFarland

6 DATE OF BIRTH (month, day, and year) Nov. 24. 1860

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	66	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md

(State or country)

PARENTS

10 NAME OF FATHER John McFarland

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann O'neill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Catherine O'neill (wife)

(Address) 1430 Jackson St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Sept 6, 1927, that I last saw h[illegible] alive on Sept 6, 1927, and that death occurred, on the date stated above, at 3.05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical sign

(Signed) Sidney H Strecth M. D.

9/7. 1927 (Address) 445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

Date of Burial Sept 9 1927

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Light St

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 25391

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25391

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital 100-001

REGISTERED NO.

City of BALTIMORE: (No. 11-30 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Parker

(a) RESIDENCE NO. Fansdowne, Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 5 1873

7 AGE — Years: 54 Months: 6 Days: 3

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Hoffman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Steinacker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant W. H. Parker

(Address) 1121 Battery Ave.

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Sept. 8

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1927 to Sept 8, 1927.

that I last saw her alive on Sept 8, 1927.

and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:

Bilateral bronchopneumonia

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. W. Peaty, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — Date of Burial: Sept 10 1927

20 UNDERTAKER: H M Cook — ADDRESS: 58 E Saratoga

very important. See instructions on back of certificates.

C. EMPSON JONES M. D.

8- 1927

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 25392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 E 25392

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1411 W 36th St. 13-57 WARD

2-FULL NAME Joseph Silva Sales

(a) RESIDENCE. No. 1411 W 36th St., 13 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 7th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Joseph Sales

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Sallie Catherine Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs. Sallie Sales
(Address) 1411 W 36th St.

15 Filed — 19 — Registrar

1927 C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Sept 8, 1927, that I last saw h alive on Sept 7, 1927, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia

Fetal remains (Premature)

(duration) — yrs. — mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an aut psy? No.

What test confirmed diagnosis? Gross Appearance

(Signed) [illegible], M. D.

9-9, 1927 (Address) 341 Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Sept 9 1927

20 UNDERTAKER W W Cook

ADDRESS So. E North Ave.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25393

CERTIFICATE OF DEATH

144 E 25393

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) Hospital for the Women of Maryland (Ward) 15-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Dora Simon

(a) RESIDENCE NO. 4301 Pimlico Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S. if of foreign birth 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: w

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis H Silver

6 DATE OF BIRTH (month, day, and year): 1902

7 AGE — Years: 25 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Simon Greenfeed

11 BIRTHPLACE OF FATHER (City or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sophie Lipsit

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Russia

14 Informant (Address): Simon Greenfeed 4301 Pimlico Rd

15 Filed ..... 19 .....

SEP 3 - 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep 8 1927

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1927, to Sep 8, 1927, that I last saw her alive on Sep 8, 1927 and that death occurred, on the date stated above, at 12:35 P.M.

The CAUSE OF DEATH* was as follows:

Placenta praevia - 7½ months.

Puerperal pelvic phlebitis

(duration) — yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary): Myocarditis - Acute.

Cardiac dilatation (duration) — yrs. — mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Delivery Date of July 19 - 1927

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John G. Murray Jr. M. D.

Sep 8. 1927 (Address) 9 East Chase Street

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehrer Rosedale — Date of Burial 9/9 19 27

20 UNDERTAKER: Jack Lewis — ADDRESS 1429 E Balto St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25394

CERTIFICATE OF DEATH.

1-002

E 25394

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Mc Mechen ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Flenellin

(a) RESIDENCE NO. 510 Mc Mechen ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ida Flenellin

6 DATE OF BIRTH (month, day, and year) Dec. 27-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	12 11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Lucian Flenellin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Lucentha Lamm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Rhoda Flenellin (Address) 510 McMechen St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8- 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 31 - , 1927, to Sept 8 , 1927, that I last saw him alive on Sept 7 , 1927, and that death occurred, on the date stated above, at 6:20 A m.

The CAUSE OF DEATH* was as follows:

Para typhoid Fever "B. Type"

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab. findings

(Signed) James Brown, M. D.

9/8, 1927 (Address) 1837 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Sept 9 1927

20 UNDERTAKER Samuel Easton

ADDRESS 716 Pa Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25395

CERTIFICATE OF DEATH.

114 E 25395

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hosp. St. 426 Ward)

2-FULL NAME Dadie Hunter Davis

(a) RESIDENCE NO. 426 Myrtle Ave St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: David Kenon

6 DATE OF BIRTH (month, day, and year): about 1880

7 AGE: Years: 47; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): General

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Morris Newman

(Address) 426 Myrtle

15 Filed.....19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 7, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquisition (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Gastro-Enteritis

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary): acute Dilatation of Heart

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Kennedy M. D.

(Coroner)

Sept. 8, 1927 (Address) 257 N Eden ston Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oliver Spgs Md Date of Burial Sept 9 1927

20 UNDERTAKER: Hamm & Carton ADDRESS 916 Pa ave

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25396

CERTIFICATE OF DEATH.

113

E 25396

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 1622 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clifton Diggs

(a) RESIDENCE NO. 1160 N. Calhoun St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		7 8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER John Diggs.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Monroe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant John Diggs

(Address) 1160 N. Calhoun St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 7/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal Indigestion

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Yates M. D.
(Coroner)

9/8/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., ...mos., less 1 ds. In the State.....yrs., 4 mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manassas Va Date of Burial Sept 9 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Pine

SEP 9-1927

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500-Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25397
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

29 E 25397
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2610 Francis ST. 13-54 WARD)

2-FULL NAME Frederick Carl Conrad Schumacher

(a) RESIDENCE No. 2610 Francis ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 31 yrs 10 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15th 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	31	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing Cutter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer J & L. Tailoring Co, Balto. Md.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS
10 NAME OF FATHER John Lewis Schumacher
11 BIRTHPLACE OF FATHER (city or town) Balto, (State or country) Md.
12 MAIDEN NAME OF MOTHER Kathrina Zimmerman
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry H. Schumacher
(Address)

15 Filed ....., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1923, to Sept 7, 1927.
that I last saw him alive on Sept 7, 1927.
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH was as follows:
Chronic Parenchymatous Nephritis
(duration) 4 yrs mos ds.
CONTRIBUTORY (Secondary) Diabetes. Heart Disease. Cardiac Paralysis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. C. Miller M. D.
19 (Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Sept 10th 1927

20 UNDERTAKER Rec. Weber & Son — ADDRESS 2503 Edmondson Ave

IMPORTANT. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25398

CERTIFICATE OF DEATH

129

E 25398

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2421 Eutaw Place St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Goldstrom

(a) RESIDENCE NO. 2421 Eutaw Place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Goldstrom

6 DATE OF BIRTH (month, day, and year) Dec. 12th. 1861.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	65	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Abraham Goldstrom

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Rachel Gruber

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. Nathan Sacks,

(Address) 2421 Eutaw Place

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8th. 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept ..., 1926, to Sept 8th, 1927, that I last saw h[illegible] alive on Sept 8 ..., 1927, and that death occurred, on the date stated above, at 1[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis - myocarditis arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY uremia (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death? [illegible]

Did an operation precede death? no Date of [illegible]

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Prudent Lentz, M. D.

Sept 9, 1927 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	Date of Burial
Baltimore Hebrew Cemetery	9/11/1927
20 UNDERTAKER David Sondheim	ADDRESS 116-20 W 2nd Royal Ave.

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Beundett.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25399

CERTIFICATE OF DEATH.

90 E 25399

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5929 Falls Road (St.) 27-53 (Ward)

2-FULL NAME Arthur Bundett

(a) RESIDENCE NO. 5929 Falls Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Jessie Bundett

6 DATE OF BIRTH (month, day, and year) Dec 11 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) O/S

(c) Name of employer Anderson

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Bundett

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Bolton 9. 8. 19 27 (Address) Int Washington md

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Jessie Bundett Int Washington md

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 , 19 27 , to Sept. 7 , 19 27 .

that I last saw him alive on Sept 7 , 19 27 ,

and that death occurred, on the date stated above, at 1. a. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of heart
Acute dilatation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) E. H. Beeton , M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Frederick | DATE OF BURIAL Sept 10 1927

20 UNDERTAKER E. Le Roy Stifflet | ADDRESS 135 E North Ave

C. HAMPSON JONES, M.

THIS IS very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25400

90 E 25400

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses H. Scales

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work minister

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Richmond Va

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7/ 1927.

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1927, to Sept. 7, 1927, that I last saw him alive on Sept. 7, 1927 and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

myocarditis chronic
arteriosclerosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Sub

(Signed) C. Holmes Burke, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn	9/10/ 1927
20 UNDERTAKER Samuel T. Hawley	ADDRESS 578 W Biddle

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 25401

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 11-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Smith

(a) RESIDENCE No. 1442 Morton St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Recorder

(Address) JOHNS HOPKINS HOSPT.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5 , 1927 , to Sept. 7 , 1927 , that I last saw h alive on Sept. 7 , 1927 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Appendicitis 1 appendiceal abscess

Peritonitis

Broncho-pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sept. 2, 1927

Did an operation precede death? Yes Date of 9-6-27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. Kidgway Trumbo M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 9/10 1927

20 UNDERTAKER Emanuel Hensley

ADDRESS 578 N. Eutaw

Spec. 1-17-27-5M-200 Bks.

E 25402

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25402

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Md Gen Hosp St. 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Ashburn

(a) RESIDENCE NO. Nems Va St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Emma Ashburn

6 DATE OF BIRTH (month, day, and year): July 14-1867

7 AGE: Years 60 Months 1 Days 25 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Ashburn

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Hayden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant: Hospital Records

(Address)

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1927 19

I HEREBY CERTIFY, That I attended deceased from Sept 2, 19 27, to Sept 9, 19 27,

that I last saw h. alive on Sept 9, 19 27,

and that death occurred, on the date stated above, at 9:55 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Cause unknown

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/9. 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Irvington, Va

Date of Burial: Sept 9 1927

20 UNDERTAKER: R. J. Tucker & Sons

ADDRESS: Kilmarnock Va

very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

E 25403 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25403

CERTIFICATE OF DEATH.

82

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 Poplar Grove ST., 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob S. Dyer

(a) RESIDENCE NO. 730 Poplar Grove ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ida Garfield Dyer

6 DATE OF BIRTH (month, day, and year) Sept 18-1848

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
78	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Woodwork

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Levin R Dyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Julia A Stamp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: D. George Ziegler

(Address): 3022 Edmondson Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 22nd, 1927, to Sept 7th, 1927, that I last saw ~~him~~ alive on Sept 5th, 1927, and that death occurred, on the date stated above, at 9-10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Nephritis

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ed. E. Cammer, M. D.

9/7, 1927 (Address) 1969 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Sept 1927

20 UNDERTAKER: Wm J Tucker & Son — ADDRESS: N. Pac

TION IS very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25404 ✓ E 25404

X88

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 7-4 Ward)

2-FULL NAME Frank W. Mohr

(a) RESIDENCE NO. Phila. Rd & Pine Grove Ave St. Ward Rosedale

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. / How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb. 2/1921

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	6	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Co., Md

PARENTS

10 NAME OF FATHER Herman H. Mohr

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Co., Md

12 MAIDEN NAME OF MOTHER Katherine Myer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Co., Md

14 Informant Herman H. Mohr

(Address) Phila Rd & Pine Grove Ave

15 Filed 1927 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 7/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Endocarditis

(Focal entry not accounted for. No autopsy) (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) J. N. Pates M. D.

(Coroner)

9/9/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Lutheran Cemetery Date of Burial Sept. 11 19 27

20 UNDERTAKER Fuller Lassahn Sons ADDRESS Fulle...

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—[illegible] Bks.

E 25405

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25405

CERTIFICATE OF DEATH

REGISTERED NO. 44

1-PLACE OF DEATH

City of BALTIMORE: (No. 733 N. Chester St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Kammerer

(a) RESIDENCE NO. 733 N. Chester St. 7 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm F. Kammerer

6 DATE OF BIRTH (month, day, and year): Oct. 29th 1865

7 AGE: Years 62 (61) | Months 10 | Days 10

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Johann Bautzer

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (City or town):

(State or country): Germany

14 Informant: Wm F. Kammerer (Husband)

(Address) 733 N. Chester St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to September 7, 1927, that I last saw h.. alive on September 7, 1927, and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd M. D.

Sept 8 1927 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial Sept 12 1927

20 UNDERTAKER: Libby & Zeller — ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

E 25406

REGISTERED NO. E 25406

1-PLACE OF DEATH

City of BALTIMORE: (No. 1705 Jackson St., 24-34 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Wm E. Burke

(a) RESIDENCE NO. 1705 Jackson St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 18, 1926

7 AGE — Years: 1 — Months: 3 — Days: 20 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Thos Burke

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary C. Noonan

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Va

11 Informant: Thos Burke

(Address) 1705 Jackson St

15 Filed ..... 19..... Registrar

SEP 5 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to Sept 5, 1927, that I last saw h alive on Sept 5, 1927, and that death occurred, on the date stated above, at 7-45 P.M.

The CAUSE OF DEATH* was as follows:

Otis Colitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Dr. H. E. Langrehr, M. D.

5, 1927 (Address) 164 S Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Cross C. G. Co. Sept 10 1927

20 UNDERTAKER — ADDRESS

Margaret J. Flynn 1422 Light St

very important. See instructions on back of certificates. Every attendant of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

E 25407 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25407
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hosp. ST., WARD)

2-FULL NAME James Douka[illegible]

(a) RESIDENCE NO. 17 Linden Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred 25 yrs mos
How long in U. S., if of foreign birth? 25 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Market man
(b) General nature of industry, business, or establishment in which employed (or employer) Sells Peanuts.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece.

PARENTS

10 NAME OF FATHER John Doukas.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece
12 MAIDEN NAME OF MOTHER Patricka Doukas.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Mrs. Doukas
(Address) 17 Linden Ave Town. Md.

15 Filed Sept 9, 19 27 RAH — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1927, to Sept 8, 1927, that I last saw h[illegible] alive on Sept. 8, 1927, and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Diarrhea

(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Carcinoma Liver with ascites (duration) yrs. mos. ds.

18 Where was disease contracted if not in place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W Warren Walker, M. D.
19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept 10 1927

20 UNDERTAKER H. C. Cook — ADDRESS 4020 Eastern

SEP 9 1927 H. RANDOLPH JONES, M. D.

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25408

CERTIFICATE OF DEATH

E 25408

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1206 Springfield Ave 27th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herskel D Dages

(a) RESIDENCE NO. 1206 Springfield Ave St. (Same) Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriet Dages

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 62 Months Days If LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore County Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Ericka Dages

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Edar Dages

(Address): 1206 Springfield Ave

15 Filed ..... 19.....

Per .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8 19 27

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 27 to Sept 7 19 27

that I last saw h.. alive on Sept 7 19 27

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Renal

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? Home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herskel D Dages, M. D.

. 19 (Address) 508 Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Rest Cem. Date of Burial: Sept 9 27

20 UNDERTAKER: Mrs. P. G. Elliott ADDRESS: 122 Ashland Ave

FEB 3 1928 H. E. BONNIWELL, M. D.

Properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25409

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25409

CERTIFICATE OF DEATH.

REGISTERED NO. 52

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 S. Catherine ST. 20th WARD)

2-FULL NAME Helen Vera Fix

(a) RESIDENCE No. 133 S. Catherine ST., 20th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? —— yrs. —— mos. —— ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year): April 13th 1916

7 AGE — Years: 11 — Months: 4 — Days: 24 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Fredrick H. Fix

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Bessie T. Hubscher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Frederick H. Fix

(Address): 133 S. Catherine St

15 Filed ....., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1927, to Sept 6, 1927, that I last saw h[illegible] alive on Sept 6, 1927, and that death occurred, on the date stated above, at 8 — P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 3 mos. 19 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) James H. Lichtenberg, M. D.

9/9 1927 (Address) 1724 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Sept 9 1927

20 UNDERTAKER: F. S. Keppler — ADDRESS: 1850 N. Bond St

C. HAMILTON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

E 25410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 E 25410

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospitals St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Boles

(a) RESIDENCE NO. 424 N Central Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 68 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858 1858

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
69	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Issicah Boles

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER un known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Beulah Boles

(Address) 1214 N. Wolf St

15 Filed.....19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Acc Fall From Window.

Fracture of Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Sept 6 1927 Signed Geo Clinton Yates M. D.

(Coroner)

(Address) 143 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mes. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary cemetery Date of Burial Sept 9 1927

20 UNDERTAKER Edward Bryan ADDRESS 651 Orleans St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25411

CERTIFICATE OF DEATH.

179

E 25411
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Ter. St. 4-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Reay

(a) RESIDENCE NO. 620 N. Mount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12 1925

7 AGE: Years 1 | Months 10 | Days 28 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Reay

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Mabel Carter

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mabel Reay
(Address) 620 N. Mount St.

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ist degree burns of body.
Accidental
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Fell into tub of boiling water
(duration) yrs. mos. ds.

(Signed) J. T. Hennessey M. D.
(Coroner)

Sept 8, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cem — Date of Burial: Sept 9th 1927

20 UNDERTAKER: Dennis Carter — ADDRESS 916 Pa ave

SEP 9 - 1927 HAMILTON JONES, M.D.

Copy of this page, with answers filled in, may be used for certificate. Every question must be answered. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9 25—A Co.—200 Bks.

E 25412

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 25412

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No. 27-48 St., Ward)

2-FULL NAME Sister Regina Quigley

(a) RESIDENCE NO. St. Mary's Asylum St., Ward

(Usual place of abode) Roland Park

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-16-1863

7 AGE: Years 63 | Months 8 | Days 22 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond

(State or country) Va.

PARENTS

10 NAME OF FATHER Wm Quigley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Sisters of Charity

(Address) Roland Park Md

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-8 1927

17 I HEREBY CERTIFY, That I attended deceased from March 22nd, 1927, to Sept 8th, 1927, that I last saw her alive on Sept 8th, 1927, and that death occurred, on the date stated above, at 2.25 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma – Sigmoid Colon

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? St. Mary's Asylum, Roland Park

Did an operation precede death? yes Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Surgical

(Signed) A. J. Knapp, M. D.

9-8, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic Cemetery — Date of Burial 9-15-1927

20 UNDERTAKER: Martin Fahrney & Sons — ADDRESS 1827 W. Baltimore St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25413

REGISTERED NO. E 25413

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Lyndhurst Ave ST. 20-71 WARD)

2-FULL NAME Josephine Wilson

(a) RESIDENCE NO. 417 Lyndhurst Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clark J Wilson

6 DATE OF BIRTH (month, day, and year): 7/12/1872

7 AGE — Years: 55 — Months: 1 — Days: 26 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimorer

PARENTS

10 NAME OF FATHER: Charles H Daiger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: E. M. Ries

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Frances Murphy (Address) 417 Lyndhurst Ave

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8 1927

17

I HEREBY CERTIFY, That I attended deceased from May, 1927, to Sept 8, 1927,

that I last saw her alive on Sept 8, 1927,

and that death occurred, on the date stated above, at 10 20 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? Yes Date of 1926

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) F. A. Kearney M. D.

, 19 (Address) 20 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 9/10 1927

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

Spec.—1-12-23—M&T—500 Bks.

E 25414

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 206 N. Franklin ST., 11 WARD)

REGISTERED NO. 24-001

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Thomas Mackenzie

(a) RESIDENCE NO. 206 N. Franklin ST., 11 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1st 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	70	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Mackenzie

11 BIRTHPLACE OF FATHER (city or town) The Cliff Calvert Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Eleanor Estrella Buckle

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Catherine M. Buckle (Address) 206 N. Franklin St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 7th 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1927, to July 14th 1927, that I last saw him alive on July 14th 1927, and that death occurred, on the date stated above, at 10 Am 9 PM.

The CAUSE OF DEATH* was as follows:

Arteric Sclerosis

to my knowledge.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Always lived in Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? History alone.

(Signed) Thomas B. Julian, M. D.

Sept 8, 1927 (Address) 129 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Friends Cemetery

DATE OF BURIAL Sept 10 1927

20 UNDERTAKER Henry H. Tenkins Sons & ADDRESS 711 Gilliat & Cathcart St

Spec.—1-12-23—MST—500 Blks.

(Strange)

E 25415

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25415

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. General Hospital ST., 14-20 WARD.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion E. Strangle

(a) RESIDENCE NO. 505 Bloom ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	36	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Marion South Carolina

PARENTS

10 NAME OF FATHER Chas. C. Winston

11 BIRTHPLACE OF FATHER (city or town) Charlestown (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Cecelia Harrison

13 BIRTHPLACE OF MOTHER (city or town) Spartanburg (State or country) South Carolina

14 Informant: Cecelia Robuck (Address) 505 Bloom St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1927, to Sept 7, 1927, that I last saw h-r alive on Sept 7, 1927 and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

17

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 11- ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operative

(Signed) Paul R Chenoweth M. D.

. 19 (Address) West Balto. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Sept 10th 1927

20 UNDERTAKER Barnes & Wright ADDRESS 1364 W Cary

HAMPSON JONES, M.

Spec.—1-12-23—M&T—500 Bks.

E 25416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 E 25416

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 7863 WARD)

2-FULL NAME Rev Aloysius Mistele

(a) RESIDENCE NO. Mount Hope Retreat ST. 28th WARD Ashland Pa
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? [illegible] mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 Years	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Catholic Priest 0/8

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Work -

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Basel, Switzerland

PARENTS

10 NAME OF FATHER Alphons Mistele

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) Switzerland

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Probably Switzerland -

14

Informant Records of Mt Hope Retreat
(Address) Baltimore Md

15

Filed ....., 19 ..... Registrar

C. CHAMPSON JONES, M. D.

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1927

17

I HEREBY CERTIFY, That I attended deceased from July 27, 1927, to Sept 1, 1927,
that I last saw h[illegible] alive on Sept 1, 1927,
and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -
Complicated by
Arteriosclerosis -
abt (duration) 10 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Senile Cyclosis -
abt (duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Ashland Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashland, Pa.

DATE OF BURIAL Sept. 13 1927

20 UNDERTAKER Lilly & Zeller

ADDRESS 403 S. Wolfe St

FROM A very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 25417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-001 E 25417

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 8-17 WARD)

2-FULL NAME Henry Huber

(a) RESIDENCE No. 1208 Rutland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Katherine Huber

6 DATE OF BIRTH (month, day, and year) June 8 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Huber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Katherine Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Katherine Huber

(Address) 1208 Rutland ave

15 Filed 1927, 19 A.K.W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/8/27 19

17

I HEREBY CERTIFY, That I attended deceased from 9/2/27, 19, to 9/8/27, 19,

that I last saw him alive on 9/8/27, 19,

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer with hemorrhage and perforation.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) septicemia and multiple abscess (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) T. P. Thompson, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 12 1927
20 UNDERTAKER	ADDRESS
J. Henry Lutz	1203 N. Broadway

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25418

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25418

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3507 N Charles St ST. WARD 12-49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Augusta Hasbach

(a) RESIDENCE No. 3507 N Charles St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Edward Hasbach

6 DATE OF BIRTH (month, day, and year) Nov 18 1874

7 AGE 52 Years 9 Months 20 Days 8 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jorge Stelas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louisa Augusta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles E Hasbach (Address) 3507 N. Charles St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 8 , 1927 , to Sept 8 , 1927 , that I last saw her alive on Sept 8 , 1927 and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of March 1/1927

Was there an autopsy? no

What test confirmed diagnosis? Microscopic exam of Tumor

(Signed) R B Wolf , M. D.

, 19 (Address) 113 W. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Sept 10 1927

20 UNDERTAKER Henry Watkins Sons — ADDRESS W. Taylor & Richard

Spec.—1-12-23—M&T—500 Blks.

E 25419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25419

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 S. Charles ST. 23-32 WARD)

2-FULL NAME Mary A. Whitten.

(a) RESIDENCE No. 1604 S. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. II mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White,	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Whitten.

6 DATE OF BIRTH (month, day, and year) Oct. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65 66	II.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER ------ Evans.

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know.

14

Informant Helen Kennedy.
(Address) 1604 S. Charles

15

Filed , 19 .

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Sept 7, 1927 that I last saw h alive on Sept 7, 1927 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Mitroe Regurgitation
+ Arterio Sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) R E Campbell M. D.

Sept 8, 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cem	Sept 10 1927

20 UNDERTAKER ADDRESS

A. Edward Evans 386 Fort Ave

Spec.—1-12-23—M&T—500 Blks.

E 25420

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25420

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 452 E. Fort Ave. ST. 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard B. Moon

(a) RESIDENCE NO. 452 E. Fort Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1927.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		6.	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard C. Moon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Agnis M. Lowery.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Agnis M. Moon,

(Address) 452 E. Fort Ave.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1927, to Sept 8, 1927

that I last saw h alive on Sept 8, 1927

and that death occurred, on the date stated above, at 6 P m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Epheumatism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Ryan V. McCampbell, M. D.

8, 1927 (Address) 1644 Harlem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem DATE OF BURIAL Sept 10, 1927

20 UNDERTAKER A. Howard Evans ADDRESS 38 E. Fort Ave

Spec.-7-17-26—A Co.—200 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25421

CERTIFICATE OF DEATH

74-001

E 25421

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 12 Evergreen Place St. 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Crowe,

(a) RESIDENCE NO. 12 Evergreen Place. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 24, 1861

7 AGE	Years	Months	Days
	66		13

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John C. Crowe

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Pritchard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Miss Mary C. Crowe

(Address) 12 Evergreen Place

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 29th, 1927 to Sept 7th, 1927

that I last saw h. alive on Sept 7th, 1927

and that death occurred, on the date stated above, at 4.10 m.

The CAUSE OF DEATH* was as follows:

Uremia Sclerosis of Coronal Vessels

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Stoner, M. D.

Sept 8, 1927 (Address) 1501 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
Greenmount Cemetery.	

20 UNDERTAKER	ADDRESS
Harry H. Poitzke	1314 W. Lombard St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25422 E 25422

CERTIFICATE OF DEATH.

1927

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 24-33 Ward)

2-FULL NAME Mrs Nellie Brady

(a) RESIDENCE NO. 113 E. Hamburg St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt Brady

6 DATE OF BIRTH (month, day, and year) March 24 1909

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
~~1~~ 18		5	14 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) El Paso, Texas

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Millard Ash

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ark.

12 MAIDEN NAME OF MOTHER Bertha Wright

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ark

14 Informant Mrs. Nellie Brady

(Address) 113 E. Hamburg City

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH (month, day, and year) 19

9-9-27

I HEREBY CERTIFY, That I attended deceased from 7-8, 1927, to 9-9, 1927,

that I last saw h.. alive on 9-9-, 1927,

and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Self-induced abortion - (2 mos ago)
Right-Tuboovarian Abscess - right
Sio-psoas abscess - right.
Chronic Endometritis yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis with effusion (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? yes Date of 8-1-27

Was there an autopsy? yes - 9-9-27.

What test confirmed diagnosis? Clinical-surgical-autopsy

(Signed) O. J. Knopp, M. D.

9-9-, 1927 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. Date of Burial Sept 12 27

20 UNDERTAKER M. J. Flynn ADDRESS 1422 Light

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 25423

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-27 E 25423

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) May Cove near Springlon ST. 97 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Bernard Flaum

(a) RESIDENCE NO. (Usual place of abode) (rear) May Cove ST. 97 WARD

Length of residence in city or town where death occurred 1 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15, 1926

7 AGE — Years: 1 — Months: 2 — Days: 24 — If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED: ?

(a) Trade, profession or particular kind of work: ?

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Gerard F. Flaum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mother

(Address)

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/3, 1927, to 9/5, 1927, that I last saw h[illegible] alive on 9/4, 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Cerebro Cortex

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Scarlet fever (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry F. Covey M. D.

..., 19... (Address) Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Sept 10 1927

20 UNDERTAKER: M. D. Flynn

ADDRESS: 142 Argyle St.

TION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bk. Richard Childs.

E 25424

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 25424

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Childs

(a) RESIDENCE NO. 1961 W. Fayette St Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Matilda A. Woodward

6 DATE OF BIRTH (month, day, and year): Nov 20 1866

7 AGE: Years 60 Months 9 Days 29

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Train Dispatcher

(b) General nature of industry, business, or establishment in which employed (or employer): United R.R. & C. Co

(c) Name of employer: [illegible]

9 BIRTHPLACE (city or town) A A Co (State or country) Md

PARENTS

10 NAME OF FATHER John N. Childs

11 BIRTHPLACE OF FATHER (City or town) A A Co (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Hardesty

13 BIRTHPLACE OF MOTHER (city or town) A A Co (State or country) Md

14 Informant Middleton J. Childs

(Address) 702 Hamilton Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 7-9-27

17 I HEREBY CERTIFY, That I attended deceased from 8-25-27 to 7-9-27, 19....., that I last saw h[illegible] alive on 7-9-27, 19....., and that death occurred, on the date stated above, at 3:20 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Colon

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Millersville A A Co. Md. Date of Burial 19 27

20 UNDERTAKER John O. Mitchell & Sons ADDRESS 1700 Eutaw Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25425

CERTIFICATE OF DEATH.

E 25425

1-PLACE OF DEATH

City of BALTIMORE: (Not Dorsey Sta - on B&O RR St., 1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl R. Jones

(a) RESIDENCE NO. 46 So. Fulton St. Ark Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22nd 1866

7 AGE: Years 61 Months 5 Days 17

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Exhibits moving Pictures at Churches

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Texas

PARENTS

10 NAME OF FATHER Lake R. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Texas

12 MAIDEN NAME OF MOTHER Elizabeth B. Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Texas

14 Informant Elizabeth B. Jones

(Address) 46 So. Fulton Ark

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8. 1927

I HEREBY CERTIFY, That I took charge of the remains described above, held a Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage

Direct By Auto RR

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Died Instantly

(Signed) Jno. B. Horton M. D.

(Coroner)

1927 Address Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem

Date of Burial 9/10 1927

20 UNDERTAKER: Robert Brookes Son

ADDRESS: Calhoun & Hollins

Cut on dotted lines, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25426

CERTIFICATE OF DEATH

31 E 25426

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Miller.

(a) RESIDENCE NO. 622 S. Millin Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8 1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
43	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 014

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Geo. Miller

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Annie (?)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant [redacted]

(Address) Same

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/8/1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1927. to Sept. 8, 1927.

that I last saw him alive on Sept. 8, 1927.

and that death occurred, on the date stated above, at 3.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis General + Symp.

(Signed) C. Hudson Burge, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. Date of Burial Sept 10 1927

20 UNDERTAKER Wendell Dippold ADDRESS 87 Lee

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HARRISON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25427 E 25427

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 179

CITY OF BALTIMORE: (No.) Fayette and Calhoun ST. (or AVE.) (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Coofser

(a) RESIDENCE NO. 25 Rich Ave ST. WARD Catonsville.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Black
5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7 1898

7 AGE — Years: 29 Months: 1 Days: 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Automobile mechanic
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Black Arrow Laundry

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS
10 NAME OF FATHER: Ben Coofser
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md
12 MAIDEN NAME OF MOTHER: Ella Haxrig
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Benj Coofser
(Address): 857 Bruce St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 . 1927 . to Sept 8 . 1927.
That I last saw h[illegible] alive on Sept 8 . 1927.
And that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:
Conflagration - clothes caught on fire, when gasoline caught fire from his automobile.
(duration) yrs. mos 4 ds.
CONTRIBUTORY (Secondary) Toxemia
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Catonsville.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) Louis N Tollin M. D.
(Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] DATE OF BURIAL: 9/11 1927

20 UNDERTAKER: Samuel T Beasley ADDRESS: 578 W Baltimore

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002 ✓ Lochbaum

E 25428

1-PLACE OF DEATH

REGISTERED NO. E 25428

City of BALTIMORE: (No. 422 S. Highland Ave Ward 26)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Groom.

(a) RESIDENCE NO. 422 S. Highland Ave Ward 26

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Mary Groom

6 DATE OF BIRTH (month, day, and year) April 15 1850

7 AGE	Years	Months	Days
	77	4	26

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wales

(State or country)

PARENTS

10 NAME OF FATHER Groom

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Wales

12 MAIDEN NAME OF MOTHER Selina Davis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Wales

14 Informant Mary E. Greef

(Address) 422 S. Highland Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from August 7, 1927, to Sept. 9, 1927, that I last saw him alive on Sept 9, 1927, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. Lochbaum, M. D.

, 19 (Address) 506 S. 34th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mount Carmel Cem	Sept 13th 1927
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25429

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25429

CERTIFICATE OF DEATH.

REGISTERED NO. 10-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2333 Guilford STREET WARD

2-FULL NAME Phillis Williams

(a) RESIDENCE NO. 2333 Guilford STREET WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Williams

6 DATE OF BIRTH (month, day, and year) Unknown 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Gloucester Co. (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Williams (Address) 2333 Guilford Ave

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 31. , 1927 , to Sept 7 , 1927.

that I last saw h alive on Sept 7 , 1927

and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Pathological Exam —

(Signed) R. Garland Connell M. D.

Sept 10. 27 (Address) 1534 E. H. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gloucester Co. Va	Sept 10, 1927
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1725 Ashland Ave

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25430

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 22-30 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luther Lee

(a) RESIDENCE No. 2 N. Conway ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of ~~~

6 DATE OF BIRTH (month, day, and year) ~~~ ~~~ 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	~~~	~~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer ~~~

9 BIRTHPLACE (city or town) (State or country) ~~~ Maryland

PARENTS

10 NAME OF FATHER Bill Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Matilda Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... RPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to Sept 7, 1927, that I last saw him alive on Sept 7, 1927, and that death occurred, on the date stated above, at 3.25 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocardial Failure

(duration) ..... yrs. 6 mos 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ..... at home.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? B. Chemistry

(Signed) Lyman Meiter, M. D.

Sept 7 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct — DATE OF BURIAL Sept 10 19 .....

20 UNDERTAKER A. R. Brown & Son — ADDRESS New Monty

Spec—12-23-21—E.B.R.S.—400 Bks.

E 25431 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 Shark St. 23-31 Ward)

Registered No.

2-FULL NAME. Rosie E Gross

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 903 Shark St St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of John Gross

6-DATE OF BIRTH (month, day and year) 1863

7-AGE. 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer). 027

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Calvert co. Md

PARENTS.

10-NAME OF FATHER. Richard Beans

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Calvert co. Md

12-MAIDEN NAME OF MOTHER. Hanna Gales

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Alice Gross

(Address) 903 S Sharf St

15-

Filed 192

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-8-27

17- I HEREBY CERTIFY, That I attended deceased from 8-24 1927 to 9-8 1927

that I last saw h[illegible] alive on 9-7 1927

and that death occurred, on the date stated above, at 7.30 a m

The CAUSE OF DEATH* was as follows:

Perforated Gastric ulcer

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Mace Williams M. D

9-9 1927 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Ct

DATE OF BURIAL. Sept 11 1927

20-UNDERTAKER. J. L. Brown & Son

ADDRESS 1012 W. Mond St

Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 25432

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25432

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland Penitentiary

City of BALTIMORE: (No. 954 Forrest St. St. 23 31 Ward) 117

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Curry

(a) Residence No. 125 Winter St., Baltic Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 4 1902

7-AGE, 25 yrs. 4 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Brickmaker.

(b) General nature of industry, business, or establishment in which employed (or employer) 026

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Little Rock Ark.

PARENTS

10-NAME OF FATHER, Joseph Curry.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14-

(Informant)

(Address) unknown

15-

Filed 192 Registrar.

Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 6 27

17- I HEREBY CERTIFY, That I attended deceased from Aug 25, 1927 to Sept 6, 1927

that I last saw him alive on Sept 6 1927

and that death occurred, on the date stated above, at 9 a m m.

The CAUSE OF DEATH* was as follows:

General Peritonitis.

with Paralytic Ileus.

(Duration) yrs. mos. 7 ds

CONTRIBUTORY (Secondary) Ruptured Appendix Perforated Ulcers,

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 1, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Chas W. Edmonds M. D.

, 19 (Address) 954 Forrest St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Sept 12, 1927
20-UNDERTAKER,	ADDRESS
J. L. Brauns & Son	101 N Mount St

Spec.-7-17-26—A Co.—200 Bks.

E 25433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25433

REGISTERED NO. 179

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp St. 4-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Charles E. Sadtler

(a) RESIDENCE NO. 1421 Eutaw Place St. Ward Resident

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 0 mos. 0 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 25 yrs. 11 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Rosabella Sadtler

6 DATE OF BIRTH (month, day, and year): October-2-1851

7 AGE — Years: 75 — Months: 11 — Days: 7 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): Self 054

(c) Name of employer: Self

9 BIRTHPLACE (city or town) Shippensburg (State or country) Penna

PARENTS

10 NAME OF FATHER Rev. Benjamine Sadtler

11 BIRTHPLACE OF FATHER (City or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Schmucker

13 BIRTHPLACE OF MOTHER (city or town) Mt. Airy (State or country) Md.

14 Informant Dr. Chas. E. Sadtler (Address) 1421 Eutaw Place

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1927, to Sept 9, 1927, that I last saw him alive on Sept 9, 1927, and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis & Cystitis

(duration) 4-5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) K & B Hurd M. D.

9-9-1927 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial: Sept-12-27

20 UNDERTAKER: STEWART & MOWEN CO. INC. — ADDRESS

WILLIAM F. MOWEN, Licensed

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25434 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-501

E 25434

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 1-3 WARD)

2-FULL NAME John Mc Donough

(a) RESIDENCE NO. 411 S Chester ST. ... WARD ...
(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 20 1875

7 AGE: Years 52 | Months 2 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: City 040

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Mc Donough

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary McDonough

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Boston

14 Informant: Gertrude Gibbons
(Address) 129 Hull St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/9/27 19

17 I HEREBY CERTIFY, That I attended deceased from 9/5/27, 19 ... to 9/9/27, 19 ..., that I last saw him alive on 9/8/27, 19 ..., and that death occurred, on the date stated above, at 7:20 A.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Laurence Hakeney M.D. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 12, 27

20 UNDERTAKER: Frank T. Pipkorn — ADDRESS: 2815 E Baltimore St

HAMPSON JONES, M. D.

THIS IS very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 25435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25435

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1313 Harlan av St. 16-26 Ward)

2-FULL NAME George Franklin

(a) RESIDENCE NO. 1313 Harlan av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Franklin

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 52 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town): Lowson

(State or country): Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): unknown

12 MAIDEN NAME OF MOTHER: Laura Franklin

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Lowson Md

14 Informant: Sarah Franklin

(Address): 1313 Harlan av

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Mar 29 1927 to Sept 7, 1927, that I last saw h.— alive on Sept 6, 1927, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Indigestion (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

9-7-1927 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: 9-11-1927

20 UNDERTAKER: Mrs Chas L. Bailey — ADDRESS: 1421 Jefferson St

Properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 11 1927 C. CLARENCE JONES, M. D.

Spec.—8-24-14—M. & T.—2000 Bks.

E 25436

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25436

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Arlington Ave St.: 16-26 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Mann

(Residence in Baltimore: No. 510 Arlington Ave St.: ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	W	Married

6-DATE OF BIRTH, Sept (Month) 7 (Day), 1858. (Year)

7-AGE,	If LESS than 1 day,
69 yrs. ....mos. 1 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Gottlieb Schanseil

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Wt Kunz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Aels

(Address) 513 W Mulberry

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept (Month) 8 (Day), 1927. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1927, to Sept 8 1927, that I saw h er alive on Sept 8 1927, and that death occurred, on the date stated above, at 7-30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

.....

.....

..... (Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Rheumatic Infection

..... (Duration) 3 yrs. ....mos. ....ds.

(Signed) C. J. Davies M. D.

9-9, 1927 (Address) 800 W 33rd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Balto Cemetery	Sept 10., 1927
20-UNDERTAKER W M Rankin	ADDRESS 223 E Pratt

Spec.–7-17-26—A Co.—200 Bks.

Dr Dean Hist Blvd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25437

CERTIFICATE OF DEATH

E 25437

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No.) 708 Carroll St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Browning

(a) RESIDENCE NO. 708 Carroll St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Browning

6 DATE OF BIRTH (month, day, and year): June 11, 1868

7 AGE: Years 59 Months 2 Days 27

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Me

(State or country)

PARENTS

10 NAME OF FATHER: Henry Mongrum

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant (Address): Howard Browning 708 Carrol St

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

OCT 10 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 9 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1 1927 to Sept 9 1927 that I last saw him alive on Sept 9 1927 and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard Dam M. D.

19 (Address) 708 Carroll St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: Sept 12 1927

20 UNDERTAKER: H H Cook — ADDRESS: 502 E North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25438

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25438

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 60 Balto Gn. Hosp (St.) 14-20 (WARD)

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Arthur Campbell

(a) RESIDENCE No. 1207 (Usual place of abode) ST. Smith WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF ~~FATHER~~ Samuel Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lydonia Blackford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Campbell (Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Sept 8, 1927

that I last saw her alive on Sept 8, 1927

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows: Acute gastro enteritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Exam & Autopsy

(Signed) Louis F. Layne M. D.

(Address) W. Balto Gn Hosp 9/8/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn. DATE OF BURIAL Sept 10 1927

20 UNDERTAKER Virginia A. Brooks ADDRESS 1531 Carey

HANSON JONES, M. D.

IMPORTANT: See instructions on back of certificates.

Spec. 17-26 1 Co.—200 Bks.

E 25439

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25439

CERTIFICATE OF DEATH

117

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Hospital for the Women of Md. St. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Sarah Rotherlaugh

(a) RESIDENCE NO. 2012 N. Charles St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 10 mos. 2 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. J. Rotherlaugh

6 DATE OF BIRTH (month, day, and year): Nov 8, 1882

7 AGE 44 Years Months 10 Days 2. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER: ? Bozeman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: L. D. Childs

(Address): 2012 N. Charles St. City.

15 Filed ..... 19 .....

ARB Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Sept. 10, 1927, that I last saw her alive on Sept. 10, 1927, and that death occurred, on the date stated above, at 1:40 A m.

The CAUSE OF DEATH* was as follows:

Gangrenous appendicitis
Peritonitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Paralytic ileus

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 2012 N. Charles St.

Did an operation precede death? Yes Date of Sept 7, 1927

Was there an autopsy? No

What test confirmed diagnosis? Confirmed at Operation

(Signed) H. H. Kroeb., M. D.

, 19 (Address) Women's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial: Sept 12 1927

20 UNDERTAKER: Chenowith & Son ADDRESS 3617 Chestnut Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1927 C. HAMSON JONES, M. D.

Per

Spec.—1-12-23—M&T—500 Bks.

E 25440 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25440

CERTIFICATE OF DEATH.

90

REGISTERED NO. 42-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3552 Roland Ave ST.) (WARD)

2-FULL NAME Mattie E Martin

(a) RESIDENCE NO. 3552 Roland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John L. Martin

6 DATE OF BIRTH (month, day, and year) Sept 28 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Curtis Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mattie E. Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Simpkins

(Address) 3552 Roland Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Sept 8, 1927,

that I last saw her alive on Sept 6, 1927,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

Hemorrhage

Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Sept 10, 1927 (Address) 3615 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Sept 10 1927

20 UNDERTAKER Chenoweth Son

ADDRESS 3615 Chestnut Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25441

CERTIFICATE OF DEATH.

E 25441

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 N. Bond ST. 7-9 WARD)

2-FULL NAME Alice Dunstan

(a) RESIDENCE NO. 633 N. Bond ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Dunstan

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edward Dunstan (Address) 633 N. Bond St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927. to Sept 8. 1927.

that I last saw h[illegible] alive on Sept 8 1927

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert L. Green M. D.

9-9. 1927 (Address) 120 Ausquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magothy D. C. Md. DATE OF BURIAL 9-11 1927

20 UNDERTAKER Jas. Wm. Skinner ADDRESS 1605 E. Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10 1927 HARRISON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E. 25442

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie FICKLING

(a) RESIDENCE No. Blackville, S.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of E. E. Fickling

6 DATE OF BIRTH (month, day, and year) Apr 16-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Geo. Kirtland

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9E 1927

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1927, to Sept. 9, 1927, that I last saw h[illegible] alive on Sept. 10, 1927, and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor, cerebello-pontine, right, non malignant.

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) — yrs. 3 weeks — ds.

18 Where was disease contracted if not at place of death? Blackville, S.C.

Did an operation precede death? Yes Date of Aug. 11, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) L. C. Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Blackville Burwell S.C.

DATE OF BURIAL Sept 10 1927

20 UNDERTAKER Kirtland & Joe

ADDRESS 1733 Eutaw

THIS is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25443 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1823 E 25th St. 49

CITY OF BALTIMORE: (No. 4-18 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary O Connor.

(a) RESIDENCE NO. 1823 E 25th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Patrick.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margret Manly.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Katherine Wynn,

(Address)

15 Filed ..... 19 ..... Registrar

TION is very important See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to Sept. 8, 1927,

that I last saw her alive on Sept. 8, 1927,

and that death occurred, on the date stated above, at 10.25 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas.

Stomach undoubtedly involved.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

9.9. 1927 (Address) 424 E. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 9-12-27

20 UNDERTAKER M. Fahey & Son ADDRESS 814 N North Ave

Spec.–7-17-26—A Co.—200 Bks.

E 25444

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25444

CERTIFICATE OF DEATH

REGISTERED NO. 27-55

1-PLACE OF DEATH

City of BALTIMORE: (No. 5308 Elmer Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna L Jefferson

(a) RESIDENCE NO. 5308 Elmer Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Isaac P Jefferson

6 DATE OF BIRTH (month, day, and year): Dec 12 - 1879

7 AGE: 47 Years 8 Months 26 Days. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Horatio Beale

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary E Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Isaac P. Jefferson

(Address): 5308 Elmer ave

15 Filed ..... 19 ..... Registrar

C. GAMSON JONES, M.D.

10 1927

ARN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1927, to Sept 8, 1927, that I last saw h[er] alive on Sept 8, 1927, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Respiratory Failure

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): Hemiplegia

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Charles Wells, M. D.

19 (Address) 5142 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial: Sept 12 1927

20 UNDERTAKER: Robt J Turner ADDRESS: 1111 Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 25445

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 E 25445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. West Baltimore General Hospital St. 1647 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert M.C.Steinbach

(a) RESIDENCE NO. 1100 Longwood St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie A. Steinbach

6 DATE OF BIRTH (month, day, and year) Aug. 5,1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	33	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Dealers

(c) Name of employer P. M. Womble

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles C. Steinbach

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary S. Reinhart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Mrs. Bessie A. Steinbach (Wife)

(Address) 1100 Longwood St.

15 Filed....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jurors (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis

(accidental)

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Fell off of Chair,

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Sept 9, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery Date of Burial 9/10 1927

20 UNDERTAKER John F. Denny ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25446

CERTIFICATE OF DEATH

74-801 E 25446

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 614 Patapsco Ave. Brooklyn Ward 25-57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva M. Nagel

(a) RESIDENCE NO. 614 Patapsco Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L. Nagel

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1897

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29	11	25 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Weaverton,

(State or country) Md.

PARENTS

10 NAME OF FATHER Homer Haines

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie Philips

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Henry L. Nagel

(Address)

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Sept 7, 1927, that I last saw her alive on Sept 6, 1927, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) A. L. Campbell M. D.

(Address) 1644 Jackson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Cedar Hill	Sept 10 1927
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 25447

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25447

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 870 W Fairmount Ave) (WARD) 16-76

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn VanBrakle Powell

(a) RESIDENCE NO. 870 W Fairmount Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Mike Powell

6 DATE OF BIRTH (month, day, and year): Sep. 22, 1901

7 AGE: Years 25 Months 11 Days 15 (14)

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

041

9 BIRTHPLACE (city or town) (State or country): Emmetsburg Md

PARENTS

10 NAME OF FATHER: John E. VanBrakle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington DC

12 MAIDEN NAME OF MOTHER: May Craig

13 BIRTHPLACE OF MOTHER (State or country): Emmetsburg Md

14 Informant (Address): Gladys Scott 870 Fairmount Ave

15 Filed 1927 . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 6 — 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1927, to Sep 6, 1927, that I last saw her alive on Sep 5, 1927, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) W. S. Powell, M. D.

9/9/27 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Sep 10 1927

DATE OF BURIAL

20 UNDERTAKER: Dennis Easton

ADDRESS E 6 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations on back of certificates.
TION is very important. See instructions on

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25448 — 144 — E 25448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Univ Hospital St. 16-22 (Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Scarbrough

(a) RESIDENCE NO. 902 N Stricker St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ____ ds. How long in U. S., if of foreign birth? yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) S. C.

PARENTS

10 NAME OF FATHER Samuel Durant

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S C.

14 Informant John Scarbrough

(Address) 902 N. Stricker St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Coroner, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Placenta Prev. Marg.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Shock

(duration) ____ yrs. ____ mos. ____ ds.

Sept 9/27 (Signed) C C Hades, M. D. (Coroner)

(Address) 143 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elliott S C. Date of Burial Sept 10 1927

20 UNDERTAKER Daniel Easton ADDRESS 94 mis

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 25449

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25449

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1229 Ashland Ave St. 10-14 (Ward)

2-FULL NAME Irvin Davis

(a) RESIDENCE NO. ~~1229 Ashland Ave~~ St._____ Ward_____
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26/1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	0	13 11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Davis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Gertrude Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md

14 Informant Mother
(Address)

15 Filed_____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ____ yrs. ____ mos. 10 ds.

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Collins, M. D.
(Coroner)
9/9/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial Sept 12 1927

20 UNDERTAKER W. H. & G. Locke ADDRESS 1342 Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25450

CERTIFICATE OF DEATH.

E 25450

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Chesapeake Bay or Upper Marsh Hospital St. Ward

(If died in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin Thrift.

(a) RESIDENCE NO. Kinsale Va. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	about 54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer) Shipping

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Walt Thrift

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mckinnon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Grace Sally

(Address) Leonardtown Md.

15 Filed SEP 10 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Sudden fall to deck of boat while at wheel. Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J C Slade M. D.

Sept 10 1927 (Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kinsale Va Date of Burial 9/11 1927

20 UNDERTAKER W. E. Mattingly ADDRESS Leonardtown Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25451

CERTIFICATE OF DEATH.

E 25451

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hosp. ST. 20-27 WARD)

2-FULL NAME Dr. Gomer E. Metherell

(a) RESIDENCE NO. 1725 Cumberland ST., WARD Rockford, Ill.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE)~~ Mrs. Hazel Metherell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Medical Doctor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Danville, Pa.

PARENTS

10 NAME OF FATHER Mrs. G.E. Metherell (Dec.)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rockford, Ill.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Record (Address)

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1927.

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1927, to Sept 10, 1927, that I last saw him alive on Sept. 10, 1927, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Induced Malaria in treatment of General Paresis.

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Bon Secour Hospl

Did an operation precede death? Yes Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) George O. Eaton M. D.

, 19 (Address) Bon Secour Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenwood Pa

DATE OF BURIAL 9/10 19 27

UNDERTAKER E. R. Stanley

ADDRESS Tullos & Lafayette

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25452

REGISTERED NO. E 25452

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St.) 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Medora Connolly

(a) RESIDENCE NO. 1306 N Rose St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Terrence Connolly.

6 DATE OF BIRTH (month, day, and year) Dec. 25/1868.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	58	8	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Michael Bey

11 BIRTHPLACE OF FATHER (City or town) Virginia

(State or country)

12 MAIDEN NAME OF MOTHER Mary [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible]

(State or country) Virginia

14 Informant Mr. Harry E. Connolly.

(Address) 1306 N. Rose st

15 Filed ..... 19 .....

Per .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Sept 8, 1927, that I last saw h[illegible] alive on Sept 8, 1927, and that death occurred, on the date stated above, at 9:50 a. m.

The CAUSE OF DEATH* was as follows:

Weakness Following Fractured Right Foot and Leg

(duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) H. Blumer, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden Date of Burial Sept 12 1927

20 UNDERTAKER J. Walter Davis ADDRESS 3307 Tunnel St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25453

1-PLACE OF DEATH

REGISTERED NO. E 25453

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward) 3-5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Crane

(a) RESIDENCE NO. 907 Eastern Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Crane ?

6 DATE OF BIRTH (month, day, and year): Sept 10 1847 ?

7 AGE: Years 80 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Patrick Buckley

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant .....

(Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 ..... Registrar

SEP 11 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Sept. 10, 1927, that I last saw her alive on Sept. 10, 1927, and that death occurred, on the date stated above, at 6:55 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic
arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Sec

(Signed) C. Holmes Bond, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patricks — Date of Burial: Sept 13 1927

20 UNDERTAKER: Randall Doppelston — ADDRESS: 37 Lamb

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25454

CERTIFICATE OF DEATH.

90 E 25454

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 715 S Bethel St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva. Kietrzyowski

(a) RESIDENCE NO. 715 S Bethel St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Kietrzyowski

6 DATE OF BIRTH (month, day, and year) Oct 15 1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER James Kiwoski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Byer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Helen Kietrzyowski

(Address) 715 S Bethel St

15 Filed 19

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1927

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, aforesaid Inquiry find that said deceased came to her death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

Sept 10 (Signed) G C Stadel M. D.

(Coroner)

19 (Address) 143 W 31st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Cross	Sept 12 1927

20 UNDERTAKER Wendell Oppelston ADDRESS 372 Cam

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25455

E 25455

CERTIFICATE OF DEATH.

124

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 553 W Barre ST. 27-30 WARD)

2-FULL NAME Timothy Walsh

(a) RESIDENCE NO. 553 W Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Annie O'Reilly Walsh.

6 DATE OF BIRTH (month, day, and year): aug 15-1857

7 AGE: Years 70 Months — Days 24 25

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired house shower

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Timothy Walsh.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Winifred Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Anna. Walsh.

(Address) 553 W Barre St.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 9th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1 1927, to Sept 9 1927, that I last saw h[illegible] alive on Sept 8 1927, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Deps

(Signed) J M Diehl M. D.

Sept 12 1927 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: Sept 12 1927

20 UNDERTAKER: John J Cowan & Son.

ADDRESS: 901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25456

CERTIFICATE OF DEATH.

90 E 25456

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1612 Poplar Grove St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Dobbie Louise Little

(a) RESIDENCE NO. 1612 Poplar Grove St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wht.	Widow

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Peter no Little

6 DATE OF BIRTH (month, day, and year)
July 4 1848

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	79	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Jno H. Samhausen
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER Elz. Trout
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Dobbie Spicer
(Address) 1612 Poplar Grove St.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Sept. 10 th 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 15 1926, to Sept. 10, 1927, that I last saw h.. alive on Sept. 9, 1927, and that death occurred, on the date stated above, at 2.45 a.m.

The CAUSE OF DEATH* was as follows:
Valvular heart. Dis.
followed by Paralysis
(Apoplexy)
(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Deafness & gradual failure of heart action
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) Edward Kirkle, M. D.
9/10, 1927 (Address) 1095 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Western Cemetery Sept 12 1927

20 UNDERTAKER — ADDRESS
Harry W. Elder 1944 W. North Ave

SEP 11 1927 G. HAMPSON JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

E 25457
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 2-4 WARD)

2-FULL NAME Anna Fink, Mrs.

(a) RESIDENCE No. 1906 E Pratt St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob L Fink

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	28	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Solomon Dessing

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Joseph Hochberg
(Address) Jewish Home

15 Filed SEP 11 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/9/27, 19, to 9/10, 1927, that I last saw her alive on 9/10/27, 19 27 and that death occurred, on the date stated above, at 8:50 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Rheumatic)
Myocarditis (Rheumatic)
Myocardial Failure

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical course, physical examination
(Signed) H. Ward Josey, M. D.
, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — DATE OF BURIAL 9/11 19 27

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balt St

THION is very important See instructions on back of certificates.

SEP 11 1927 C. HAWKINS JOHNS, M. D.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 25458

CERTIFICATE OF DEATH.

E 25458

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl Weiser

(a) RESIDENCE NO. 102 S. 10th St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec/25/26

7 AGE	Years	Months	Days	IF LESS than 1 dny.....hrs. or.....min.
		10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work XXXX

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Earl Weiser

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Mo

12 MAIDEN NAME OF MOTHER Elizabeth ----

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mo

14 Informant Earl Weiser

(Address) 102 S. 10th St

15 Filed..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(Possible septic Origin. Autopsy at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Jos K Cole M. D.
(Coroner)

9/10/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St Joe Mo	9/10/27
20 UNDERTAKER	ADDRESS
Joseph Ahern	221 Busey

SEP 11 1927

Be sure and be entirely legible. All 4 sides should be filled. Use INK EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25459

E 25459

CERTIFICATE OF DEATH

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1424 Darley Ave 8-45 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Freitag.

(a) RESIDENCE NO. 1424 Darley Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): WIDOWED.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Freitag

6 DATE OF BIRTH (month, day, and year): May 24/43

7 AGE — Years: 84 — Months: 3 — Days: 16 — If LESS than 1 day hrs. nr min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Freitag

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. John Seigmeth (Address) 1424 Darley Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 19 27 to Sept 10 19 27

that I last saw him alive on Sept 10 19 27

and that death occurred, on the date stated above, at 11.30a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Myocardi-tis & Chr Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Schenuit, M. D.

19 (Address) 1337 E Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M. Olivet — Date of Burial 9/12 19 27

20 UNDERTAKER: William Cook — ADDRESS 522 E Madison

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HAMILTON JONES, M. D.

SEP 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25460 X 45 E 25460

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital 25-72

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew D Adams

(a) RESIDENCE NO. Parkersburg W. Va St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Adams

6 DATE OF BIRTH (month, day, and year): Mar 25 1851

7 AGE: Years 76 Months 5 Days 15 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Minister none

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town): Pa

(State or country)

PARENTS

10 NAME OF FATHER: Andrew Adams

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Towsend

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Penn Pa

14 Informant: Wm A Dr. Adams

(Address): Parkersburg W. Va

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-10 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-7, 1927, to 9-10, 1927, that I last saw him alive on 9-10, 1927, and that death occurred, on the date stated above, at 6 45 p. m.

The CAUSE OF DEATH* was as follows:

Lympho-sarcoma Retroperitoneal Lymph glands

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Termind Broncho-pneumonia and Cardiac Dilatation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? at home.

Did an operation precede death? yes Date of 9-8-27.

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & surgical

(Signed) Eg Knapp, M. D.

9-10, 1927 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkersburg W. Va — Date of Burial: 9/14 1927

20 UNDERTAKER: Robert Brookeson — ADDRESS: Cor Calhoun Hollins St

SEP 11 1927 C. Harvey Jones, M. D. Registrar

For ... Registrar

DO NOT fail to state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 25461 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25461

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 S. Schroeder ST. 18-W WARD)

2-FULL NAME Mary Dugan

(a) RESIDENCE No. 127 S. Schroeder ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20-1856

7 AGE — Years: 71 — Months: — Days: 18 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER Patrick Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant Mrs Dugan

(Address) 127 S Schroeder St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8. 1927.

17

I HEREBY CERTIFY, That I attended deceased from Sept 1 1927. to Sept 8 1927.

that I last saw her alive on Sept 8 1927.

and that death occurred, on the date stated above, at 830 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis.

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopic etc.

(Signed) J. Thos. Norton. M. D.

9/10/27 (Address) 888 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL: Sept 12 1927

20 UNDERTAKER: John Shields — ADDRESS: 1200 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Emile Dueker.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25462

CERTIFICATE OF DEATH

E 25462

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emile Dueker

3870 St Laurent Blvd

(a) RESIDENCE NO. Montreal – Canada St. Ward Not Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~ Single

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) 8/6/1900

7 AGE: Years 27 Months 1 Days 5 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) Montreal

(State or country) Canada

PARENTS

10 NAME OF FATHER Samuel Dueker

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Canada

12 MAIDEN NAME OF MOTHER Sophie Stone

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Canada

14 Informant

(Address) Hosp. Record.

15 Filed SEP 11 1927, 19 ; HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/6, 1927, to 9/11, 1927, that I last saw h[illegible] alive on 9/11, 1927, and that death occurred, on the date stated above, at 12 20 a.m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Peritonitis & Toxemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted Unknown

if not at place of death?

Did an operation precede death? Yes Date of 9/6/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible], M. D.

9/11, 1927 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Royal Canada — Date of Burial 9/11 1927

20 UNDERTAKER: H. Thompson & Bro — ADDRESS 1127 E Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25463

CERTIFICATE OF DEATH.

90 E 25463

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1431 Gough St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris O'Keefe

(a) RESIDENCE NO. 1431 Gough St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day.....brs. or.....min.
About	62	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Employ by
(b) General nature of industry, business, or establishment in which employed (or employer): City Street Cleaning
(c) Name of employer: Department

9 BIRTHPLACE (city or town)
(State or country): Salts Md

PARENTS

10 NAME OF FATHER: Morris O'Keefe

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Daley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Ireland

14 Informant: Mr Thomas O'Keefe
(Address) 1209 Ensor St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsies or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

Duration: yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

Duration: yrs. mos. ds.

Sept 10 1927 (Signed) G E Gladden, M. D.
(Coroner)
(Address) 1432 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: Sept 12 1927

20 UNDERTAKER: Henry Hoech & Son — ADDRESS: 1301 E Eager St

(Stamp) SEP 10 1927 HAMPSON JONES M.D.

Filed Sept 10 1927

Registrar

(Cor.—12-9-25—A Co.—200 Bks.)

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25464

CERTIFICATE OF DEATH

E 25464

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3908 Philadelphia St., 26-39 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Selkirk C. Ulbig

(a) RESIDENCE NO. 3908 Philadelphia Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 2 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): February 8 1927

7 AGE — Years: — Months: 7 Days: 22 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Herman A Ulbig

11 BIRTHPLACE OF FATHER (City or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary B. Baker

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Mr. Herman A. Ulbig

(Address) 3908 Philadelphia Rd.

15 Filed SEP 11 1927 19 Per C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/9, 1927, to 9/10, 1927

that I last saw him alive on 9/10 1927

and that death occurred, on the date stated above, at 4:40 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulm Oedema

Uremia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry L. L. Siddall M. D.

(Address) 6323 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Sept 13 1927

20 UNDERTAKER: Henry Hoen & Son — ADDRESS: 1301 E. Eager St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 V

E 25465
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) W. Balto Gen Hosp (Street) 6-71 (WARD)

2-FULL NAME Louis Weber

(a) RESIDENCE NO. 3716 Edmondson Ave. WARD
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Weber

6 DATE OF BIRTH (month, day, and year) Feb 4, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	7	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocery
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS
10 NAME OF FATHER Francis Weber
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.
12 MAIDEN NAME OF MOTHER Cecelia Drottenhet
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Hospital Rec

15 Filed , 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1927

I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to Sept 9, 1927, that I last saw him alive on Sept 9, 1927, and that death occurred, on the date stated above, at 12 45 a. m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Uremia Coma - 3 days)
(duration) yrs. 10 mos ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clin. Exam
(Signed) Louis T. Leon, M. D.
9/9, 1927 (Address) W. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Cathedral Cem — DATE OF BURIAL 9/12 1927

20 UNDERTAKER Geo W Farley Fulton Ave — ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Little · 2435 Maryland Ave

Spec. 7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25466

CERTIFICATE OF DEATH

129 E 25466

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 East 23rd St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace M Townsend

(a) RESIDENCE NO. 103 East 23rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John O Townsend

6 DATE OF BIRTH (month, day, and year): Dec 30, 1850

7 AGE — Years: 76 Months: 8 Days: 10 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER: John Martimer

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER: Maria Elsworth

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country) Md

14 Informant: Florence Townsend

(Address) 103 E 23rd St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 10 1927

17 I HEREBY CERTIFY, That I attended deceased from ....., 1917, to Sept 10, 1927,

that I last saw her alive on Sept. 10, 1927,

and that death occurred, on the date stated above, at 12:40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis (arterio sclerosis)

(duration) many yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted? —

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo M Little M. D.

9/10. 1927 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial: Sept 12 1927

20 UNDERTAKER: J. H. Cook — ADDRESS 502 North Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 25467

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124 E 25467

REGISTERED NO.

1-PLACE OF DEATH: Md Gen Hosp St. 11-24 Ward)

City of BALTIMORE: (No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Burket

(a) RESIDENCE NO. Md Gen Hosp St. Ward Hagerstown Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Harry Burket

6 DATE OF BIRTH (month, day, and year) Apr 2 1875

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) farming

(c) Name of employer self

9 BIRTHPLACE (city or town)

(State or country) Washington Co Md.

PARENTS

10 NAME OF FATHER Daniel Burket

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Gabriel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna

14 Informant Harry Burket

(Address)

15 Filed SEP 11 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927 to Sept 11, 1927,

that I last saw him alive on Sept 11, 1927,

and that death occurred, on the date stated above, at 9 10 m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Cerebral hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 9/2/27

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Jno A Weaver M. D.

, 19 (Address) Hagerstown Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Wash Co Md Date of Burial Sept 11 1927

20 UNDERTAKER Lowe Cook ADDRESS 50 E North

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25468

84 E 25468

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4203 ST. PAUL ST. (WARD) 27-49

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WILLIAM FREDERICK BREEBACK

(a) RESIDENCE NO. 4203 ST. PAUL ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	MARRIED

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) EMMA MEYERS BREEBACK

6 DATE OF BIRTH (month, day, and year) DEC. 15, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work RETIRED

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) BALTIMORE MD

PARENTS

10 NAME OF FATHER CARL BREEBACK

11 BIRTHPLACE OF FATHER (city or town) (State or country) GERMANY

12 MAIDEN NAME OF MOTHER ANNA RICHARDS

13 BIRTHPLACE OF MOTHER (city or town) (State or country) GERMANY

14 Informant MRS EMMA BREEBACK

(Address) 4203 ST PAUL ST.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) SEPT 9 1927

17 I HEREBY CERTIFY, That I attended deceased from JULY 30, 1925, to SEPT 9, 1927.

that I last saw him alive on SEPT 4, 1927,

and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

ANGINA PECTORIS

(duration) 6 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? HOME

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? SIGNS & SYMPTOMS

(Signed) James E. Peterman, M. D.

, 19 (Address) 1228 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Sept 14 1927

20 UNDERTAKER Jos Jourdens + Son — ADDRESS 27 S Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25469

100-001

E 25469

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Zapalorowisch

(a) RESIDENCE NO. 2555 Fait St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Wh

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: not attained

6 DATE OF BIRTH (month, day, and year): Aug 3 1871

7 AGE: Years 56 Months 1 Days 6

IF LESS than 1 day.....hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~Iron Laundry~~ Oiler

(b) General nature of industry, business, or establishment in which employed (or employer): Iron Moulder

(c) Name of employer: Iron Foundry

9 BIRTHPLACE (city or town): Poland

(State or country)

PARENTS

10 NAME OF FATHER: Frank Zapalorowisch

11 BIRTHPLACE OF FATHER (City or town): Poland

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Poland

(State or country)

14 Informant

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-9 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-7, 1927, to 9-9, 1927.

that I last saw him alive on 9-9, 1927.

and that death occurred, on the date stated above, at 3 15 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertention, arterio sclerosis Emphysema

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. findings, X-Ray

(Signed) C. Hamilton Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus cem — Date of Burial: Sep 12 1927

20 UNDERTAKER: John McAbee — ADDRESS: 1803 Bank

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

25470

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25470

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hosp. St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lucy Northington Warfield

(a) RESIDENCE NO. Hoodbine Md St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Domestic work

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widow

6 DATE OF BIRTH (month, day, and year): June 7- 1857

7 AGE — Years: 70 Months: 3 Days: 4 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(e) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Enoch Bishop Hutton

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Jones

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Son: Joshua N Warfield

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1927, to Sept 11, 1927, that I last saw him alive on Sept 11, 1927, and that death occurred, on the date stated above, at 12:43 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy (Cer)

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary): Fractured hip - Bronchopneumonia

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Hammond M. D.

. 19 (Address) Union Memorial Hosp. Md 33rd & Calvert Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Howard Co Md Cemetery

Date of Burial: Sept 2 19 27

20 UNDERTAKER: Scott M. Shaw

ADDRESS: Ellicott City

SEP 14 1927

Reg

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Emma Knight ✓ 25x90

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25471

CERTIFICATE OF DEATH.

90 E 25471

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1939 N. Calvert ST., 27-44 WARD)

2-FULL NAME Emma Knight

(a) RESIDENCE NO. 4305 Norwood Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) ---------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel T. Knight

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Moore

13 BIRTHPLACE OF MOTHER (city or town) Harford Co
(State or country) Maryland

14 Informant Mrs. J. Edwin Murphy
(Address) 4305 Norwood Road

15 Filed SEP 11 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10. 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1926, to Sept 10, 1927, that I last saw h[illegible] alive on Sept 10, 1927, and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis —

about 3 mos —
(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis —

Several —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? None —

(Signed) Chas W. Lawrence, M. D.

Sept 11 1927 (Address) 137 Park Ave, Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	9/12 1927
20 UNDERTAKER Henry U. Wears & Son	ADDRESS 1505 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 11 1927 HEALTH DEPT

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25472

1-001

E 25472

REGISTERED NO.

1. PLACE OF DEATH

City of BALTIMORE: (No. 1157 Carroll St., 21-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Louise Griffith

(a) RESIDENCE NO. 1157 Carroll St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 9 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March, 21st 1912

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	15	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sales lady

(b) General nature of industry, business, or establishment in which employed (or employer): Store

(c) Name of employer: Mr Wick

9 BIRTHPLACE (city or town): A. A. Co.

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert L. Griffith

11 BIRTHPLACE OF FATHER (City or town): A.A. Co

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mamie E. Catterton

13 BIRTHPLACE OF MOTHER (city or town): Calvert Co.

(State or country): Maryland

14 Informant: Mrs. Olive Ward

(Address): 1145 Carroll St.

15 Filed ..... 19 ..... Registrar

SEP 12 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September, 10th. 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Sept 10, 1927, that I last saw her alive on Sept 10, 1927, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Toxaemia Tuberculosis Lung

(duration) ..... yrs. 1 mos. 10 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sigmoidoscopy Stomach Tube

(Signed) Walter E. Culley, M. D.

(Address) 57 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem West River Md.

Date of Burial: Sept 12 1927

20 UNDERTAKER: Kemp & Cook

ADDRESS: 1003 N Bltz St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25473 ✓ 100-01 **E 25473**

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 S. Clinton St. 26-1 WARD)

2-FULL NAME Mary E. Smith

(a) RESIDENCE NO. 1219 S. Clinton ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 1-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	-	9	9	8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Harrison P. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary E. Yaeger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Harrison P. Smith
(Address) 1219 S. Clinton St

15 Filed ....., 19 RLK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 1927 to Sept 9 1927

that I last saw her alive on Sept 9 1927

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tilton M. D.

9/10, 1927 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery DATE OF BURIAL Sept 12 1927

20 UNDERTAKER George W. Zirkler ADDRESS 1737 E. Eager St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25474

REGISTERED NO. **E 25474**

1-PLACE OF DEATH

City of BALTIMORE: (No. 1716 Barclay St. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Irene Theresa Williams Preedue Mc Cathran

(a) RESIDENCE NO. 1716 Barclay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Bosley McCathran

6 DATE OF BIRTH (month, day, and year) Apr 1 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	5	9	8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Irene Theo. McCathran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary E. Danner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Anna M. Cathran (Address) 1716 Barclay

15 Filed ..... 19..... C. HERBERT JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Valv disease Heart

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (Duration) ..... yrs. ..... mos. ..... ds.

Sept 11 (Signed) C. H. Jones M. D. (Coroner)

, 19 27 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs.. mos.. ds. In the State ..... yrs.. mos.. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Date of Burial Sept 9 1927

20 UNDERTAKER Mary M Wiedefeld ADDRESS 50 E 25th

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 25475

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25475

CERTIFICATE OF DEATH.

1827

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Jas 3. Pratt ST. 14-20 WARD)

2-FULL NAME Jas H- Morris

(Residence in Baltimore: No. 2133 N. Bond St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

10 St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	colrd	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE	If LESS than 1 day,
38 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Student
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE. (State or Country). Salisbury Md

PARENTS.

10-NAME OF FATHER, Jas Morris

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER M. Peters

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Broadwater Morris

(Address) 2133 N. Bond

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 11 27, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to. his death on the day stated above.

The CAUSE OF DEATH* was as follows:

C. O. C. Ludy Running

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Ludy (Coroner) M. D.

Sept 11, 1927 (Address) 1639 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In State Couple years ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery — DATE OF BURIAL, Sept 12 1927

20-UNDERTAKER Clarence E. Wright — ADDRESS 1264 N. Carey

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25476

E 25476

CERTIFICATE OF DEATH

X 129

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1369 N. Carey St. St. 15-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Coulter

(a) RESIDENCE NO. Gainsville Florida St. Ward Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Coulter

6 DATE OF BIRTH (month, day, and year) 12-25-1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	73	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Auburn Ala

(State or country)

PARENTS

10 NAME OF FATHER Milton Joplin

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mildred Orr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Auburn Ala

14 Informant Sister Lela Williams

(Address) 1369 N. Carey St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9—11— 1927

17 I HEREBY CERTIFY, That I attended deceased from 8—7—, 1927, to 9—11—, 1927, that I last saw her alive on 9—11—, 1927, and that death occurred, on the date stated above, at 2:45 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY Chronic nephritis + myocarditis

(Secondary)

(duration) 1? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Gainsville Florida

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Frank A Saunders M. D.

. 19 (Address) 1029 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial Sept 13 1927

20 UNDERTAKER

ADDRESS

Lawrence E. Wright 1364 Mary

SEP 12 1927 HEALTH DEPT.

Filed

Registrar

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19[illegible] L. P. [illegible] E 25477

HEALTH DEPARTMENT—CITY OF BALTIMORE E 25477

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 126 Patapsco av. ST.: 27-75 WARD 80

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucretia Dunn

(a) RESIDENCE. No. 176 Patapsco av ST., WARD. 27

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 4 27

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bath Md

PARENTS

10 NAME OF FATHER Jacob Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Carolina

12 MAIDEN NAME OF MOTHER Lucy Chandler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mother

(Address) 176 Patapsco Av

15 Filed ..... 19 .... Registrar .....

SEP 12 1927 C. HAYDON [illegible]

Per RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1927, to Sept 10, 1927,

that I last saw her alive on Sept 10, 1927.

and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas L Wells M. D.

19 (Address) 1742 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cem

DATE OF BURIAL Sept 12 1927

20 UNDERTAKER John F Owens

ADDRESS 638 Dolphin

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NAME should be clearly supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-12-23—M&T—500 Blks.

25478

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25478

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Lombardy apts.

CITY OF BALTIMORE: (No. 10 E. Lombard St. ST. 17-49 WARD)

2-FULL NAME Emma Crist.

(a) RESIDENCE NO. Lombardy apts. ST. Guilford WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Philip Crist

6 DATE OF BIRTH (month, day, and year) July 17 1849.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John P. Ronsselot.

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Charlotte Brecks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Berlin Germ.

14 Informant Frank A. Crist (Address) Lombardy apts.

15 Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1927

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to Sept 10, 1927, that I last saw her alive on Sept. 10, 1927, and that death occurred, on the date stated above, at 3.40 A m

The CAUSE OF DEATH* was as follows:

Valvular myocarditis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Clinical

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Gast, M. D.

, 19 (Address) 5101 Reisterstown Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Sept 12th 1927
20 UNDERTAKER Henry Jenkins Sons Co.	ADDRESS Orchard & Howard

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 25479

CERTIFICATE OF DEATH.

E 25479

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-bt Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Schwaber

(a) RESIDENCE NO. 4015 Rathland Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frieda Schwaber

6 DATE OF BIRTH (month, day, and year): March 1 - 1891

7 AGE: Years 36 | Months 6 | Days 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Building Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): 016

(c) Name of employer: Oscar C Rosenthal

9 BIRTHPLACE (city or town): Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Schwaber

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Galicia

12 MAIDEN NAME OF MOTHER: Rebecca Schlossberg

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Galicia

14 Informant: Nathan Berkowe

(Address): 2900 Parkwood Ave.

15 Filed....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept 11 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 8, 1927, to Sept 11, 1927, that I last saw h im alive on Sept 11, 1927, and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Milton Sheppy, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rundals — Date of Burial: Sept 12 1927

20 UNDERTAKER — ADDRESS: Jack Krowe, 1439 E. Balto St.,

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25480

CERTIFICATE OF DEATH.

45 **E 25480**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5029 Gwynn Oak Ave ST., 28-6 WARD)

2-FULL NAME William Henry Linthicum

(a) RESIDENCE NO. 5029 Gwynn Oak Ave ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Ellen Elizabeth Linthicum

6 DATE OF BIRTH (month, day, and year) Aug 7/1842

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ... min.
85	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired civil engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 0&6

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel Co
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Eleanora Travers
(Address) 5029 Gwynn Oak Ave

15 Filed ... 19 ... C. HAMPSON JONES, M.D. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept 8 , 1927 , to Sept 10 , 1927 ,

that I last saw her alive on Sept 10 , 1927 ,

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ... yrs. ... mos 5 - ds.

CONTRIBUTORY (Secondary) Cancer Stomach

about (duration) 3 yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical - Phys

(Signed) Hubert Dorsey, M. D.

, 19 (Address) 5150 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 13 1927

20 UNDERTAKER: Joseph Leper — ADDRESS: 1600 W Fayette St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25481

CERTIFICATE OF DEATH.

88

E 25481

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 513 Calvin ST. 5-8 WARD)

2-FULL NAME John Wilson

(a) RESIDENCE NO. 513 Calvin ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Wilson

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER James Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Ada West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 Informant Hattie Wilson

(Address) 513 Calvin st

15 Filed SEP 13 1927, 19 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10 — 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 29, 1927, to Sept 5, 1927, that I last saw h alive on Sept 5, 1927, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) — yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein, M. D.

9/10, 1927 (Address) 733 Augusta st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: Sept 13 1927

20 UNDERTAKER: Eduard Bryan — ADDRESS: 1631 orleans st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25482

CERTIFICATE OF DEATH.

129

REGISTERED NO. E 25482

1-PLACE OF DEATH

City of BALTIMORE: (No. 236 N. Dunbar St St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Toles

(a) RESIDENCE NO. 236 N. Dunbar St (Usual place of abode) St. Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Toles

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Solomon Toles

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Cora Toles

(Address) 236 Durham St

15 Filed SEP 12 1927 19 C. Hincy Jones M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

(Signed) C. H. Jones M. D.
(Coroner)

9/12 19 27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
White Stone Va	9/12 19 27

20 UNDERTAKER Edward Bryan ADDRESS 1631 Adams.

N. B.—WHITE PAPER, WITH CARBON BACK—This Certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25483

CERTIFICATE OF DEATH

X 15 | E 25483

REGISTERED NO. 11424

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General Hospital St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Frizzell

(a) RESIDENCE NO. Westminster Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): 2 Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 2/5/1852

7 AGE: Years 75 Months 7 Days 6 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Jesse W Frizzell

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Roxana D Annis

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Hosp. Records

(Address)

15 Filed ..... 19 .....

Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 9-11-27

17 I HEREBY CERTIFY, That I attended deceased from 8-8-27, 19..... to 9-11-27, 19.....

that I last saw h(im) alive on 9-11-27, 19.....

and that death occurred, on the date stated above, at 2.35 P. m.

The CAUSE OF DEATH* was as follows:

Gangrene of left leg

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) General arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted: —

If not at place of death?

Did an operation precede death? yes Date of 8-9-27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carroll, Taylorsville Cemetery

Date of Burial: Sept 13 1927

20 UNDERTAKER: C. M. Metz

ADDRESS: Finksburg Md

SEP 12 1927

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25484 — PLACE OF DEATH

188-003

2435

REGISTERED No. E 25484

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephan Czaplicki.

(a) RESIDENCE NO. 1406 Decatur St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or ~~WIFE of~~) Helen Czaplicki.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Stanislaus Radowski. (brother in law)

(Address) 1244 Hull St.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 9, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull. Thrown from a side car of motor cycle in collision with rear of a moving Ford car.

Accidental Death.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

9/10 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Patapsco Ave & 8th St. Brooklyn,

Former or usual residence Sept. 4, 1927.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross. Date of Burial: 9/13 1927

20 UNDERTAKER: Wm. Graefsowski. ADDRESS: 1618 Eastern

RRK

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25485

CERTIFICATE OF DEATH.

E 25485

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 S. 6th ST., 25-37 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel B. Burl.

(a) RESIDENCE No. 110 S. 6th ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) July 27-1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edward Burl.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella. Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Burl. (Address) 1106 E 31st.

15 Filed SEP 12 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11th 1927

17 I HEREBY CERTIFY, That I attended deceased from September 9th, 1927, to September 11th 1927, that I last saw him alive on September 10th 1927 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Out Floor of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examinations

(Signed) Henry Heribel M.D.

9/12/1927 (Address) 1214-12 Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 9/12 1927

20 UNDERTAKER J. Flew McCully — ADDRESS 130 E. Front

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25486 HEALTH DEPARTMENT—CITY OF BALTIMORE

23 E 25486

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1311 N. Eden St

CITY OF BALTIMORE: (No. Fenay C. W Lule St. 9-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 1311 N. Eden St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 24. 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
7 mos.	0	7	16	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Chas. W Lule

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Bessie Harryman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Charles White

(Address) 1311 N. Eden st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 1927, to Sept 10 1927, that I last saw him alive on Sept 9 1927 and that death occurred, on the date stated above, at 2 A m

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos. X ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Frahm, M. D.

9/10, 1927 (Address) 1823 N. Hust St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 12 1927

20 UNDERTAKER George - L Ruth

ADDRESS 1735 Harford Ave

Station should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25487 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 25487

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2437 Barclay st ST.) 17-50 WARD)

2-FULL NAME William P. Creigh.

(a) RESIDENCE NO. 2437 Barclay st ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Margaret Creigh.

6 DATE OF BIRTH (month, day, and year): Oct. 4 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Later.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

0+0

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William P. Creigh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs. Mary Creigh. (Address) 2437 Barclay st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 8 1927 to Sept 10 1927, that I last saw h[illegible] alive on Sept 10 1927 and that death occurred, on the date stated above, at about 8:30 a m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

6 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency per days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. J. Riley, M. D.

Sept 11, 1927 (Address) 1059 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Sept 14 1927

20 UNDERTAKER: Geo. F. Rutter

ADDRESS: 1235 Harford ave.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25488

101-001

101-E 25488

CERTIFICATE OF DEATH

1-PLACE OF DEATH St. Joseph's Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 12 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ann Schaub.

(a) RESIDENCE NO. 815 N. Milton ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Schaub.

6 DATE OF BIRTH (month, day, and year): 1889.

7 AGE: Years 38; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Housekeeper.

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jacob Busch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Margaret Dietzsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore.

14 Informant: Margaret E. Roehrlin

(Address) 815 N. Milton ave

SEP 12 1927

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 10 1927.

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to Sept 10, 1927, that I last saw her alive on Sept 10, 1927, and that death occurred, on the date stated above, at 4:45 P.m.

The CAUSE OF DEATH* was as follows:

Empyema of Left Kidney

(duration) yrs. mos ? ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

(duration) yrs. mos. 2 0 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of 7/22/27.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H Lawrence Fahrney, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery. DATE OF BURIAL: Sept. 14 1927

20 UNDERTAKER: Geo. L. Rust. ADDRESS: 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25489

E 25489

CERTIFICATE OF DEATH.

24-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 106 E. 20th St. (Ward) 17-19

2-FULL NAME Mary C. Alheit

(a) RESIDENCE. No. 106 E. 20th St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of John A. Alheit

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Altenstädt, Germany

PARENTS

10 NAME OF FATHER — Theis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Martin Alheit 106 E. 20th St.

15 Filed . 19 C. HARRISON JONES, M. D. Registrar

SEP 12 1927

Per K P K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1927 to Sept. 11, 1927 that I last saw her alive on Sept. 11, 1927 and that death occurred, on the date stated above, at 12:15 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 10 ds

CONTRIBUTORY (Secondary) Arterio-Sclerosis — Old age. (duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. H. Pannebaker, M. D.

. 19 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem'y	Sept 13 1927
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2175 S. Pac

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25490

CERTIFICATE OF DEATH

117

E 25490

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md Gen Hosp St. 45-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles Beauchamp

(a) RESIDENCE NO. 2114 91 North Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 91 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Chas Beauchamp

6 DATE OF BIRTH (month, day, and year) Oct 24 1890

7 AGE	Years	Months	Days
	36	10	17

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 003

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John T Beauchamp

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Hawkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Chas Beauchamp

(Address) 2114 N. North Ave

15 Filed SEP 12 1927 19 Registrar C. HOWARD JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Sept 10, 1927, that I last saw h[illegible] alive on Sept 10, 1927, and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows: Ruptured appendix

(duration) yrs. mos. 4 (?) ds.

CONTRIBUTORY (Secondary) Pen peritonitis 4 da (?)

Septic pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Sept 11 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial Sept 15 1927

20 UNDERTAKER F. A. Schwaneke Son ADDRESS 703 Hamp

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25491 E 25491

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hosp. (ST.) 14 (WARD) 20

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Joyce

(a) RESIDENCE NO. 747 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert T Joyce

6 DATE OF BIRTH (month, day, and year): Nov. 22nd 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co.

PARENTS

10 NAME OF FATHER: Joshua German

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co.

12 MAIDEN NAME OF MOTHER: Julia Ann Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co.

14 Informant: Andrew German

(Address): 747 E. Preston St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/10/27 19

17

I HEREBY CERTIFY, That I attended deceased from 8/22/27 .19 , to 9/10/27 .19 ,

that I last saw her alive on 9/10/27 .19 ,

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitis

Multiple Abscess

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary): Pneumonia - Bronchial

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Laurence Fahnestock M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Ver M. E. Cemetery

DATE OF BURIAL: Sept 13 1927

20 UNDERTAKER: Frederick Sasaha Sons

ADDRESS: Fullerton

Mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 17 1927

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-901

E 25492

CERTIFICATE OF DEATH.

REGISTERED NO. E 25492

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 310 - 22½ St. 12-50 Ward)

2-FULL NAME Gerald Johnson

(a) RESIDENCE NO. 310 - 22½ St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1899

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Lola Higgs

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Lola Higgs

(Address) 310 22½ St.

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 16 1927, to Sept 7 1927, that I last saw h... alive on Sept 8 1927, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

a Broncho Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. 1 mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Johnson, M. D.

, 19 (Address) 2529 Guilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cuta Md. Date of Burial Sept 11 1927

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1225 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25493 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1629 (St.) Ashland Ave (WARD) 17

REGISTERED No. 25493

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Bracho

(a) RESIDENCE NO. 1629 (St.) Ashland ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Bracho

6 DATE OF BIRTH (month, day, and year): [illegible] 1889

7 AGE — Years: 38 — Months: — Days: — If LESS than 1 day, hrs or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: James Epps

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Brasdlite Fentress

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): James Epps 1629 Ashland ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Sep. 5, 1927 to Sep. 8, 1927 that I last saw h[illegible] alive on Sep. 8, 1927 and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

appendicities

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Medical

(Signed) J. H. Walter M. D.

, 19 (Address) 1635 N. Caldery St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: Sept 11 1927

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 1775 Ashland Ave

SEP 12 1927 H. BOYLES, M. D.

marion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25494

E 25494

CERTIFICATE OF DEATH

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS Ward) 7731

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Shanks.

(a) RESIDENCE NO. 111 E. Hughes St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 68 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Fred Shanks

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) BALTIMORE CITY HOSPITALS

15 Filed C. 19

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10/1927.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1927, to Sept. 10, 1927

that I last saw him alive on Sept. 10, 1927

and that death occurred, on the date stated above, at 6:00 a. m.

The CAUSE OF DEATH* was as follows:

Post encephalitic Parkinsonian syndrome

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Gen.

(Signed) C. Stulz de Burg, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial: Sept 13 1927

20 UNDERTAKER: John H. Denny — ADDRESS: 715 Lights

SEP 12 1927 RECEIVED

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 E 25495

REGISTERED NO.

1-PLACE OF DEATH
E 25495
City of BALTIMORE: (No. 828 S Wolfe St. 3-4 Ward)

2-FULL NAME Stanislaw Olszewski

(a) RESIDENCE NO. 828 S Wolfe St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11-1871

7 AGE: Years 56 Months 1 Days 29. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Adam Olszewski

(Address) 339 S Regester St

15 Filed ..... 19.. Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest aforesaid, find that said deceased came to death as stated.

(Coroner or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

1a Alcoholism

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Sept 10 1927 (Signed) G C Broder M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sts Stanislaus Date of Burial: Sept 13 1927

20 UNDERTAKER: John M Weber ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25496 E 25496

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Jasper St., 6-12 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Dora Kauffholz

(a) RESIDENCE NO. 1114 N Patterson Park Ave WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Ferdinand Kauffholz

6 DATE OF BIRTH (month, day, and year) May 18 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John A. Thiess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Dora E.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Ferdinand Kauffholz
(Address) 1114 N. Pat. Pk. Ave

15 Filed ..... 19 .....
For RHH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to Sept 10, 1927,

that I last saw her alive on Sept 10, 1927,

and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma breast left

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Generalized Metastases

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George B Baird, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore | DATE OF BURIAL Sept 13 27

20 UNDERTAKER Philip Herring | ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

20594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25497
1-PLACE OF DEATH

REGISTERED NO. 90 E 25497

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 11-24 WARD)

2-FULL NAME Abraham Meyers

(a) RESIDENCE NO. 1102 Myrtle Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Maryland

PARENTS

10 NAME OF FATHER John Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise Gant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1927, to Sept 10, 1927, that I last saw him alive on Sept 10, 1927, and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Emphysema Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Lyman Wells, M. D.

9/11, 1927 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hamilton Cem Calvert Co Md

DATE OF BURIAL Sept 12 1927

20 UNDERTAKER Daniel T Easton

ADDRESS 916 Dr ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25498

CERTIFICATE OF DEATH.

44 E 25498

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2027 Brunt St. 44-20 Ward)

2-FULL NAME Oscar Young.

(a) RESIDENCE NO 2027 Brunt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer General

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Emma Diggs

(Address) 746 Fairmount Ave

15 Filed ..... 19 ..... Registrar

SEP 12 1927 HEALTH COMMISSIONER

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma (Stomach)

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Sept. 12 19 27 (Address) 2572 Eu. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Sept 12 19 27

20 UNDERTAKER Daniel Easton ADDRESS 916 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25499 E 25499

CERTIFICATE OF DEATH.

129

16-22

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 N. Appleton St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Fuchs,

(a) RESIDENCE. No. 910 N. Appleton ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 14 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced [illegible] of (or) WIFE of Paul Fuchs.

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1860

7 AGE	Years	Months	Days	If less than 1 day, hrs. or min.
	67	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Maurer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Fuchs (Address) 910 N. Appleton St.

15 Filed SEP 12 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1927, to Sept. 10, 1927, that I last saw her alive on Sept. 10, 1927, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Insanity

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History, Symptoms, Hem.

(Signed) John D. Quinn, M. D.

Sept. 12, 1927 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

New York NY 9/14/27

UNDERTAKER — ADDRESS

Temple & Turley, Fulton Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25500 (upper right) 124 E 25500

REGISTERED NO.

E 25500

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1400 Hollins St. 4-28 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella D. Porter

(a) RESIDENCE NO. 1400 Hollins St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (~~write the word~~)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. H. Porter

6 DATE OF BIRTH (month, day, and year) Aug 31 = 73

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	54	nr	nr	12 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Delaware

PARENTS

10 NAME OF FATHER Daniel C Adams

11 BIRTHPLACE OF FATHER (City or town)..

(State or country) Delaware

12 MAIDEN NAME OF MOTHER Deborah Morris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Delaware

14 Informant J. H. Porter

(Address) 1400 Hollins St

15 Filed SEP 12 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from June 30 1927, to Sept. 12 1927,

that I last saw h[illegible] alive on Sept. 11 1927,

and that death occurred, on the date stated above, at 12:15 a. m.

The CAUSE OF DEATH* was as follows: Chronic Endocarditis

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

Nephritis (duration) 2 yrs. 12 mos. ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopic

(Signed) Daniel Klingenberg M. D.

9/12 1927 (Address) 1722 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bridgeville Del — Date of Burial Sept 13 1927

20 UNDERTAKER Robert Brooks & Son — ADDRESS [illegible] Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25501

CERTIFICATE OF DEATH.

49

E 25501

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1015 West Cross ST. (WARD) 21-29

2-FULL NAME George Ho. Hillary Sr

(a) RESIDENCE NO. 1015 West Cross ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACT CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowered

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie E. Hillary

6 DATE OF BIRTH (month, day, and year): 11-25-1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ... min
56	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chief Bkpr

(b) General nature of industry, business, or establishment in which employed (or employer): Fuse Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Hillary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary A. O'Grady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mary V. Nolan
(Address): 1015 West Cross St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to Sept 10, 1927, that I last saw h— alive on Sept 9, 1927 and that death occurred, on the date stated above, at 20 Sep m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobaris.

(duration) ... yrs. 9 mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [signature], M. D.

9/11, 1927 (Address) 5[illegible] Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: 9/13/27

20 UNDERTAKER: William Cook — ADDRESS: 502 E. North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25502

REGISTERED NO. E 25502

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals - W. 26. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Murphy

(a) RESIDENCE NO. Woodlawn Ave. Near Reisterstown Road St.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Murphy

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE — Years: 55 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): Espionage

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Patrick Murphy

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Virginia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Hospital Records.

(Address): Balto City Hosp

15 Filed SEP 13 1927 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 1927 to Sept 10 1927

that I last saw h.. alive on Sept 10 1927

and that death occurred, on the date stated above, at 1 1 P. m.

The CAUSE OF DEATH* was as follows:

Cathma, Bronchial

Acute Myocardial failure

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) L. E. Madden M. D.

9-10-27 (Address) Balto City Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial: Sept 14 1927

20 UNDERTAKER: W. H. Cook — ADDRESS 502 E North Ave

Spec.—1-12-23—M&T—500 Blks.

E 25503 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1528 East Balto St. (WARD) 14

2-FULL NAME Alice A. Walker

(a) RESIDENCE No. 1528 East Balto ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: James H. Walker

6 DATE OF BIRTH (month, day, and year): Sept 4 1860

7 AGE — Years: 67 — Months: 0 — Days: 8 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Ward Tyrell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass.

12 MAIDEN NAME OF MOTHER: Sarah Arrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs H. S. Cole

(Address): 1525 East Balto

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 13 1927 to Sept 12 1927, that I last saw him alive on Sept 11 1927 and that death occurred, on the date stated above, at 3.05 P m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uremic Intoxication

(duration) 5 yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. D. Fuck M. D.

9/17 1927 (Address) 436 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Kampden

DATE OF BURIAL: Sept 15 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E25504

HEALTH DEPARTMENT—CITY OF BALTIMORE

E25504

CERTIFICATE OF DEATH

101-06

1-PLACE OF DEATH

REGISTERED NO. 26-36

City of BALTIMORE: (No. BALTIMORE CITY HOSPI[illegible] St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Filipa

(a) RESIDENCE NO. 55 So 8th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Filipa

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE 49 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron moulder

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Austria

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

M BALTIMORE CITY HOSPITALS

Informant

(Address) [illegible]

15 Filed [illegible] 19 [illegible] Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-12 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-11, 1927, to 9-12, 1927, that I last saw him alive on 9-12, 1927, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes Autopsy

What test confirmed diagnosis?

(Signed) C. Holmes O'Boyle, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — Date of Burial: Sept 15 1927

UNDERTAKER: Frank Crackson — ADDRESS: 1906 Aisquith

SEP 14 1927 C. HAWKINS O'BOYLE M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

E 25505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25505

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4915 Haddon Ave (ST.) 2863 (WARD)

2-FULL NAME William Columbus Detmer

(a) RESIDENCE NO. 4915 Haddon Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~or WIFE~~ Mrs. Rita Detmer

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	48	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer B. & O. Railroad

9 BIRTHPLACE (city or town) (State or country) Hethsville, Balto County, Md

PARENTS

10 NAME OF FATHER William Henry Detmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto County, Md.

12 MAIDEN NAME OF MOTHER Elizabeth McCommon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mrs. Elizabeth Detmer 4915 Haddon ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1927 to Sept. 11, 1927 that I last saw h alive on Sept. 11, 1927 and that death occurred, on the date stated above, at 7.50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Angina Pectoris

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Decompensation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical diagnosis

(Signed) A. Allen Mason M. D.

19 (Address) 2040 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept 14 1927

20 UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

25506 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 25506 CERTIFICATE OF DEATH. E 25506

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2917 Erdman Ave ST. 8-45-49 WARD)

2-FULL NAME Henry B. Painter

(a) RESIDENCE NO. 2917 Erdman Ave ST., WARD Eastern Shore Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Painter

6 DATE OF BIRTH (month, day and year): 10/23/1855

7 AGE — Years: 71 Months: 10 Days: 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa

PARENTS

10 NAME OF FATHER: John Painter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Orville Painter
(Address): 2937 Erdman Avenue

15 Filed ... 19 ...
Per ... Registrar

C. HAMILTON JONES, M. D.

SEP 12 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1927, to Sept 10, 1927, that I last saw him alive on Sept 9, 1927, and that death occurred, on the date stated above, at 10-50 m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Prostate & Bladder).

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopy,

(Signed) E. H. Arnold, M. D.

, 19 (Address) 8/ Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 9/13 1927

20 UNDERTAKER: Albert L Hiltz Jr — ADDRESS: 1606 N Chester St

MARGIN RESERVED FOR BINDING

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25507

CERTIFICATE OF DEATH.

E 25507

113

1—PLACE OF DEATH

CITY OF BALTIMORE, (No.) 637 Ashland ST. 7-13 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nelson Crawford Scott

(a) RESIDENCE No. 637 Ashland ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): ~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~

6 DATE OF BIRTH (month, day, and year): 9/9/27

7 AGE — Years: | Months: | Days: 3 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED: ~

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): ~

(c) Name of employer: ~

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): .....

12 MAIDEN NAME OF MOTHER: Mary Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs. Delia Scott
(Address) 637 Ashland

15 Filed ..... 19 .....

Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/12 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/9 – 1927, to 9-12, 1927,

that I last saw him alive on 9-11, 1927,

and that death occurred, on the date stated above, at 9:30 A. m.,

The CAUSE OF DEATH* was as follows:

Acute Jaundice and Enteritis

(duration) ~ yrs. ~ mos 3 ds.

CONTRIBUTORY (Secondary): Congenital defect

(duration) ~ yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. R. Blake M. D.

9-13, 1927 (Address) 427 Ashland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: Sept 13 1927

20 UNDERTAKER: Thomas H. Keating — ADDRESS: 718 N Bridge

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 1 - 1927

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25508

CERTIFICATE OF DEATH

E 25508

1-PLACE OF DEATH U. M. Hosp. REGISTERED NO. 101001

City of BALTIMORE: (No. 33rd & Calvert St.) (1-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Philip March

(a) RESIDENCE NO. 1004 Russell St. Balt. Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W	baby.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22/27

7 AGE Years Months 2 Days 19 IF LESS than 1 day hrs. or min.
10 weeks

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt. Md.
(State or country)

PARENTS

10 NAME OF FATHER Philip Frederick March

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mamie Groscup

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Records
(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Sept 11/27

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1927, to Sept 11, 1927, that I last saw him alive on Sept 11/27, 19, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:
Unknown until autopsy
Patch of Pneumonia at base
(duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted
If not at place of death? Hospital ?
Did an operation precede death? no Date of
Was there an autopsy? Yes.
What test confirmed diagnosis?

(Signed) K. J. Belford, M. D.
9-11, 1927 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — Date of Burial Sept 13 1927

20 UNDERTAKER Thos. J. Fields — ADDRESS 1200 W Lombard

C. H. WILSON JONES, M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25509

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

1924 E 25509

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1124 N. Lombard ST. 18-24 WARD)

2-FULL NAME Hannah F. Cline,

(a) RESIDENCE NO. 1124 N. Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. \ mos. \ ds. How long in U. S., if of foreign birth? \ yrs. \ mos. \ ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT WRITE IN THIS SPACE RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Cline,

6 DATE OF BIRTH (month, day, and year): Dec. 26. 1853

7 AGE — Years: 74 — Months: 8 — Days: 17 — If LESS than 1 day, \ hrs. or \ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Housework.

(c) Name of employer: none,

9 BIRTHPLACE (city or town) (State or country): Virginia.

PARENTS

10 NAME OF FATHER: William Cox,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sarah Baldin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Jos Niebert

(Address): Hagerstown Md

15 Filed ... 19 ... Registrar

SEP 13 1927 C. HAMILTON HOLMES, M.D. RLH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1927, to Sept 12. 1927.

that I last saw her alive on Sept 12. 1927,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) \ yrs. \ mos 1 ds.

CONTRIBUTORY (Secondary): Chronic Int. Nephritis

(duration) \ yrs. 6 mos. \ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Time Analysis etc.

(Signed) Thos Norton, M. D.

9/12/27. (Address) 888 N. Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harper's Ferry West Va

DATE OF BURIAL: Sept 13 1927

20 UNDERTAKER: H. J. Fields

ADDRESS: 1200 W Lombard

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25510
1-PLACE OF DEATH

REGISTERED NO. E 25510

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1025 Harlem Ave ST., 16-26 WARD)

2-FULL NAME Olivia Bell Mason

(a) RESIDENCE NO. 1025 Harlem Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen R Mason

6 DATE OF BIRTH (month, day, and year) Feb 20 – 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jeff Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Blatchy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Lena R Fisher
(Address) 1025 Harlem Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12th 1927

17

I HEREBY CERTIFY, That I attended deceased from June 12 , 1927 , to Sept 12 , 1927.

that I last saw her alive on Sept 10 , 1927,

and that death occurred, on the date stated above, at 830 A. m.

The CAUSE OF DEATH* was as follows:

Cardio vascular Hypertension

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Central hemorrhage

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo M Smith, M. D.

9/12 1927 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Sept 13 1927

20 UNDERTAKER Wm J Tichnors & Co — ADDRESS Catherine

PRINTING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25511

CERTIFICATE OF DEATH.

E 25511

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1012 N. Fulton Ave Ward 6-2)

2-FULL NAME George Benson Frey

(a) RESIDENCE NO. 1012 N. Fulton Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 5 mos. 18 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabelle M. Frey

6 DATE OF BIRTH (month, day, and year) Mar 23 1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Beef Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Louis Frey

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Gray

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Isabelle M. Frey

(Address) 1012 N. Fulton Ave.

15 Filed Sept 13 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) C C O Cirrhosis

(duration) ... yrs. ... mos. ... ds.

Signed J. T. Hennessy M. D. (Coroner)

Sept 11, 1927 (Address) 2577 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem Date of Burial Sept 13 1927

20 UNDERTAKER Wm Hickner Sons ADDRESS Mord & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25512

CERTIFICATE OF DEATH.

90 E 25512

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1443 Henry ST. 24-33 WARD)

2-FULL NAME William P. Thompson.

(a) RESIDENCE NO. 1443 Henry ST. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 8 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evangelin Thomson

6 DATE OF BIRTH (month, day, and year) 12-31-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	70	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Norkon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norkon

14 Informant Mr. Thompson (Address) 1443 Henry St.

15 Filed . 19 R.L.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11 1927

17

I HEREBY CERTIFY, That I attended deceased from May 27th, 1927, to Sept 11th 1927

that I last saw h— alive on Sept 10th 1927

and that death occurred, on the date stated above, at 4 H m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis and chronic aortic regurgitation

(duration) — yrs. 3 mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Tony Leibel M. D.

9/13. 1927 Address 1224 26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 9/13 1927

20 UNDERTAKER J. Fav McCully

ADDRESS 130 E Fay

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25513

CERTIFICATE OF DEATH.

E 25513

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Fort of Wolfe, 18-76 Ward)

2-FULL NAME Nathaniel Humphrey Lee

(a) RESIDENCE NO. Deceased 715 Bennett St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	W M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town)

(State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) yrs. mos. ds.

(Signed) C. Hadley M. D.

(Address) 1743 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interred and buried in Westerly Cemetery Date of Burial Sept 14 1927

20 UNDERTAKER Chas. D. Beach ADDRESS 742 N Howard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—tion should be carefully supplied. AGE should OF DEATH in plain terms, so that it may be very important. See instructions on back of

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 25514 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. E 25514

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1145 May ST. 5-8 WARD)

2-FULL NAME Josepline Jones

(a) RESIDENCE NO. 1145 May ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced (or) WIFE of Robert Jones

6 DATE OF BIRTH (month, day, and year) Unknown 867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 070

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Annie Lee (Address) 1145 May St.

15 Filed , 19 RHC Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept 1 , 19 27 , to Sept 10 , 19 27 ,

that I last saw h alive on Sept 9 , 19 27

and that death occurred, on the date stated above, at 7:10 A m

The CAUSE OF DEATH* was as follows:

Cardio Renal

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

(Address) 508 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL Sept 13 27

20 UNDERTAKER Mrs. R. C. Elliott ADDRESS 775 Washington Ave

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important See instructions on

SE 15 1926 HAROLD JOYCE, M. D.

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25515

CERTIFICATE OF DEATH

REGISTERED NO. E 25515

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 E 21st St., 4-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Doyle

(a) RESIDENCE NO. 515 E 21 st St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25 1870

7 AGE: 37 Years 3 Months 17 Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Instructor

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore md
(State or country)

PARENTS

10 NAME OF FATHER John C Doyle

11 BIRTHPLACE OF FATHER (City or town) N. Y.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine McConnell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore md
(State or country)

14 Informant Catherine Doyle
(Address) 515 E 21st St

15 Filed ..... 19 ..... Registrar

SEP 13 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1927

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1927, to Sept 12, 1927, that I last saw him alive on Sept 11, 1927, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of March 27

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) William F Love, M. D.

. 19 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: Sept 14 1927

20 UNDERTAKER: Robt F Turner — ADDRESS: N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25516

8-17 129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 E Fairvale ST.) (8 WARD)

2-FULL NAME Elizabeth Fager

(a) RESIDENCE No. 1602 E Fairvale ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm H Fager

6 DATE OF BIRTH (month, day, and year) Nov 10 60

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	66	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER A Silberzahn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Zucker

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Wm H Fager
(Address) 1602 E Fairvale

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10/27 19

17 I HEREBY CERTIFY, That I attended deceased from 9/10/27, 19 , to 9/10/27, 19 ,

that I last saw h[illegible] alive on 9/10/27, 19

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (?) Nephritis

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

(Address) 525 Stiles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL Sept 13 1927

20 UNDERTAKER Wm Rouston — ADDRESS 2238 N Smith

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

SEP 13 1927 H. A. JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25517

CERTIFICATE OF DEATH.

74001

E 25517

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 640 Sterling ST., (WARD) 5-8

2-FULL NAME Lavinia Hawkins

(a) RESIDENCE NO. 640 Sterling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Paul Hawkins

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 58; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Jennie Solomon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dublin Ireland

14 Informant (Address): Paul Hawkins 640 Sterling st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 18 1927 to Sept 10 1927, that I last saw her alive on Sept 10 1927, and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) [redacted] Senile Gangrene

(duration) yrs mos 25 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) George E Allen, M. D.

(Address) 508 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 9/13 1927

20 UNDERTAKER: Byron Wright

ADDRESS 1218 Mc Elderry St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25518

E 25518

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp. St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Raphael S. Payne

(a) RESIDENCE NO. Pikesville Md St. Non Resident Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mrs Raphael S Payne

6 DATE OF BIRTH (month, day, and year): June 3, 1860

7 AGE: Years 67 Months 3 Days 8 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Banker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Virginia

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Rice W. Payne

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: American Summers

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Lexington Ky

14 Informant: Martin Memorial Hosp

(Address)

15 Filed SEP 13 1927, 19 Registrar

C. HERBERT JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH, (month, day, and year) 1927: September 12 — 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1927 to Sept 12, 1927

that I last saw h~~e~~r alive on Sept 12, 1927

and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix - Peritonitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? at hospital

Did an operation precede death? yes Date of 8-30-27

Was there an autopsy?

What test confirmed diagnosis? obvious

(Signed) Frank E. Morris, M. D.

9/12, 1927 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md

Date of Burial: Sept 13 19

20 UNDERTAKER: Harry A. Jenkins & Bro

ADDRESS: Forward

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25519

CERTIFICATE OF DEATH

E 25519

REGISTERED NO. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals Ward) 3-5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Mitchell

(a) RESIDENCE NO. 1010 Bradley St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 56 Years Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) England

(State or country)

PARENTS

10 NAME OF FATHER Leo Mitchell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant

(Address) Hospital Records

15 Filed , 19

Per Registrar

SEP 13 1927 HAYDEN JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1927 to Sept 9, 1927

that I last saw him alive on Sept 9, 1927,

and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH* was as follows:

Diabetes Gangrene Right Foot & leg

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhagic Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Aug. 10, 1927

Was there an autopsy? no

What test confirmed diagnosis? Pathologic Examination Laboratory

(Signed) Meyerowitz, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial Sept 14 1927

20 UNDERTAKER: Kendall Dysard — ADDRESS 378 N

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25520

CERTIFICATE OF DEATH.

E 25520

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2641 Boone ST., (WARD) 9-46

2-FULL NAME Carlene Stewart

(a) RESIDENCE NO. 2641 Boone ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 2 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Arthur Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Spence

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Ozna Stewart 2641 Boone st.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1927, to Sept 11, 1927, that I last saw her alive on Sept 11, 1927, and that death occurred, on the date stated above, at 6.20 p m.

The CAUSE OF DEATH* was as follows:

Acute Entero Colitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) General Exposure to Summer Heat (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. B. Hall, M. D.

, 19 (Address) 426 623 Dr.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: Sept 13 1927

20 UNDERTAKER: Mrs. R. C. Elbert — ADDRESS: 1725 Archland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25521

CERTIFICATE OF DEATH

E 25521

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 Pennington Ave Street 25-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth F. Nehrkorn

(a) RESIDENCE NO. 920 Pennington Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Nehrkorn

6 DATE OF BIRTH (month, day, and year): July 28, 1885

7 AGE: Years 41 Months 1 Days 12 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Geo. W. Potts

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ellicott City Md.

12 MAIDEN NAME OF MOTHER: Amelia Schramm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Herman Nehrkorn

(Address) 920 Pennington Ave.

15 Filed SEP 13 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 11 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 19 27 to Sept 11 19 27

that I last saw h alive on Sept 11 19 27

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. 1 mos. ... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) L. M. Bowers M. D.

19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial Sept. 13 1927

20 UNDERTAKER: Margaret G. Flynn ADDRESS 1417 Eight St.

Spec.—1-10-21—M&T—1500 Bks.

E 25522 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 4209 Liberty Heights Ave ST.) 21-64 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Turner

(a) RESIDENCE NO. 4209 Liberty Heights Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of William B. Turner

6 DATE OF BIRTH (month, day, and year) --------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	55	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Hugh Kerne

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Isabel McGeheen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant James Turner
(Address) 4209 Liberty Heights Ave.

15 Filed SEP 13 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12- 1927.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1921 to Sept. 12- 1927, that I last saw her alive on Sept. 12- 1927, and that death occurred, on the date stated above, at 12.45 A.m.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis
(duration) 6 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Myocardial Disease
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

9/12. 1927 (Signed) Cook Shiering, M. D.
(Address) 1120 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 9/14 19 27

20 UNDERTAKER Henry H. Mears & Son — ADDRESS 805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25523

90 E 25523

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

REGISTERED NO. 26-37

City of BALTIMORE: (No. [redacted] St. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Clay

(a) RESIDENCE NO. None given St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE 42 Years Months Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): md

(State or country)

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country): md

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): md

14 Informant: Olivia Rodgers

(Address): 720 Carrollton ave

15 Filed [illegible], 19 [illegible] C. HAMPSON JONES, M. D. Registrar

Per [illegible]

SEP 13 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-8 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-13, 1923, to 9-8, 1927, that I last saw her alive on 9-8, 1927, and that death occurred, on the date stated above, at 705 P m.

The CAUSE OF DEATH* was as follows:

Acute & Chronic myocarditis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted?

If not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) C. Hampson Jones M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: Sept 13, 27

20 UNDERTAKER: Newton Easton — ADDRESS: 916 Pa ave

BALTIMORE CITY HOSPITALS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 25524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 25524

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 12-59 Ward)

2-FULL NAME Elex Seidell

(a) RESIDENCE NO. 2017 Callow ave St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 37 yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fanne Seidell

6 DATE OF BIRTH (month, day, and year): Abt 1860

7 AGE — Years: 67 — Months: — — Days: — — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: H. Hamburger

(Address): 2408 Callow ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 13, 1927 — 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1927, to Sept 13, 1927, that I last saw him alive on Sept 13, 1927, and that death occurred, on the date stated above, at 3:10 A m.

The CAUSE OF DEATH* was as follows: Carcinoma of Pleura

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary): Pulmonary edema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical signs & autopsy

(Signed) Abram J. Rechtman, M. D.

9-15, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Orphan Asylum — Date of Burial 9/14 1927

20 UNDERTAKER: Jack Levin — ADDRESS 1439 E Balt St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25525

CERTIFICATE OF DEATH.

186-003

E 25525

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) West Balto. Gen Hosp St., 20-69 Ward)

2-FULL NAME Eloise S. Barrett

(a) RESIDENCE NO. 2648 W. Franklin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred City yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Barrett

6 DATE OF BIRTH (month, day, and year): March 12, 1869

7 AGE: Years 57 Months 5 Days 28 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER: Joseph Selby

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER: Blanche White

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Baltimore Md

14 Informant: Marie B. Alain

(Address) 2648 W Franklin St

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull, fracture of both femurs

(duration) ..... yrs. ..... mos. 6 hrs. ..... ds.

CONTRIBUTORY (Secondary) Struck by automobile

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Fleming M. D.

(Coroner)

1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: Sept 14 1927

20 UNDERTAKER: George J. Smith — ADDRESS: 532 Hollins

SEP 15 1927 C. LARSEN SONS, INC.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 25526

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25526

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO. 26-37

City of BALTIMORE: (No. Baltimore City Hospitals St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levi Holmes

(a) RESIDENCE NO. Balto. City Hospitals St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER Mitchell Holmes

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Violet Christian

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 19

Registrar

1694 RRN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 8, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from April 19 27, 19, to Sept. 8, 27, 19,

that I last saw him alive on Sept. 8, 19 27,

and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lymphosarcoma

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Labo.

(Signed) E. E. Madden, M. D.

9-8-, 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25527

CERTIFICATE OF DEATH

E 25527

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital St. 11-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Brooks

(a) RESIDENCE NO. Hanlestown Rd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-10-27

7 AGE — Years — Months — Days: 3 — IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Evan Bacon

11 BIRTHPLACE OF FATHER (City or town) (State or country) Catonsville Md.

12 MAIDEN NAME OF MOTHER Blanche Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Catonsville

14 Informant (Address)

15 Filed ... 19... C. HAMILTON JONES, M.D. Registrar

SEP 18 1927

1699

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/10, 1927, to 9-13, 1927, that I last saw h[illegible] alive on 9-12, 1927 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis
mal development due to
Twin - Preg nancy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Carlson, M. D.

9/13, 1927 (Address) 808 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial ... 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health

SEP

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25528

E 25528

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

2-FULL NAME Albert M. Jones

(a) RESIDENCE NO. 941 Luzerne St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O+O

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) md

PARENTS

10 NAME OF FATHER Sam Jones

11 BIRTHPLACE OF FATHER (City or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Hester Carlton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-23 1927 to 9-10 1927

that I last saw him alive on 9-10 1927

and that death occurred, on the date stated above, at 9 10 P m.

The CAUSE OF DEATH* was as follows:

Tumor, of Brain

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Holmes Brown M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodbury Cem	9-14 1927
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1626 E. Broad St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25529

E 25529

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2518 Aisquith St. 9-46 WARD)

2-FULL NAME August Broemer

(a) RESIDENCE NO. 2518 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hermine Broemer

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	63	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 5 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Broemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hermine Broemer

(Address) 2518 Aisquith St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1927

17

I HEREBY CERTIFY, That I attended deceased from June 6, 19 27, to Sept 11, 19 27,

that I last saw h alive on Sept 11, 19 27,

and that death occurred, on the date stated above, at 3 45 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion - Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Pharynx

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Jones, M. D.

9/12 1927 (Address) 4 786 Hampden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 14 1927

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS 1710 Fleet St.

9-13-1927 C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

Sadie A. Luckett

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25530

CERTIFICATE OF DEATH

90 **E 25530**

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Sadie A. University Hospital St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs ~~J. Parker~~ Luckett

(a) RESIDENCE NO. 1324 N Bond St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. Parker Luckett

6 DATE OF BIRTH (month, day, and year): Oct 11=1859

7 AGE: Years 67 Months 11 Days 1 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Samuel Wilson

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Parker Luckett

(Address) 1324 N. Bond st

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: September 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1927, 19..... to Sept 12, 1927 19....., that I last saw h-e alive on Sept 12, 1927, 19....., and that death occurred, on the date stated above, at 2:20 P M

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage, Hypertension Cardio-vascular disease.

(duration) Three Hours

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John Roberts Phillips, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial: Sept 15 1927

20 UNDERTAKER: Henry Lutz — ADDRESS 1203 N. Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 1 1927 C. HAMILTON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25531

E 25531

REGISTERED NO. 7400

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2800 Eastern Ave. St. (Ward) 15-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose L. Sommerfeld

(a) RESIDENCE NO. 2800 L. Sommerfeld St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): Dec 5 1867

7 AGE — Years: 59 Months: 9 Days: 7 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Pa.

(State or country)

PARENTS

10 NAME OF FATHER Adolph Sommerfeld

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Cecelia Lisker

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Mrs. Louis Herstein

(Address) 3807 Park Heights Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Sept. 12,

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1925, to Sept 8 1927,

that I last saw h.. alive on Sept 8 1927,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) one (1) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 12 yrs. ..... mos. ..... ds.

18 Where was disease contracted

if not at place of death?

id an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ohel Shalom Cemetery Date of Burial: Sept 15 1927

20 UNDERTAKER: J. Aronson & Co. ADDRESS: 2432 Reisterstown Rd

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 25532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25532

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1820 E Biddle ST. (WARD) 8-13

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mary Swagler

(a) RESIDENCE NO. 1820 E Biddle ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Swagler

6 DATE OF BIRTH (month, day, and year): Nov 26 1857

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
69	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frederick Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mary Stiltenbrick (Address) 1820 E Biddle st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to Sept 12, 1927, that I last saw h alive on Sept 12, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frederick E. Karnes M. D.

Sept 15, 1927 (Address) 1301 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Sept 15 1927

20 UNDERTAKER: Henry Lutz — ADDRESS 1209 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25533

CERTIFICATE OF DEATH

E 25533

1-PLACE OF DEATH University Hospital

REGISTERED NO. 117

City of BALTIMORE: (No. 1 St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Harry Downey

(a) RESIDENCE NO 1142 Scott St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ruth Eyler

6 DATE OF BIRTH (month, day, and year): 1896

7 AGE: Years 31 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer): W B & A

(c) Name of employer

9 BIRTHPLACE (city or town): Laurel, Md.

(State or country)

PARENTS

10 NAME OF FATHER: Jesse A Downey

11 BIRTHPLACE OF FATHER (City or town): Laurel, Maryland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary E Knapp

13 BIRTHPLACE OF MOTHER (city or town): Laurel

(State or country) Maryland

14 Informant: Len Schneider

(Address) 1142 Scott St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1927, to Sept 12, 1927

that I last saw him alive on Sept 12, 1927

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Suppurative Appendicitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Sept 10 1927

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. J. Sartwell, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ivy Hill Cem Laurel — Date of Burial: 9/14 1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state cause OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25534 (26) — HEALTH DEPARTMENT—CITY OF BALTIMORE — E 25534

CERTIFICATE OF DEATH.

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 23-39 WARD)

2-FULL NAME Maurice J. O'Neale

(a) RESIDENCE No. 8 East Barney St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed or Divorced~~ (write the word): Child

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) April-30-1921

7 AGE: Years 6 yrs | Months 4 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington, D. C

PARENTS

10 NAME OF FATHER: Hidrey O'Neale

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ida Dissey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): D. Columbia

14 Informant: Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 PPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1926, to Sept 13, 1927, that I last saw him alive on Sept-13, 1927, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Empyema Pneumonia

Pleurisy

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 14+ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 25 1927

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Allan Blossom, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL 10/16 1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS Calvert Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

13 1927 C. HARRISON, M. D. Reg.

Spec.–7-17-26—A Co.—200 Bks.

E 25535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 25535

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1922 E Madison St. 7-13 Ward)

2-FULL NAME Richard McCall

(a) RESIDENCE NO. 1922 E Madison St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katie M McCall

6 DATE OF BIRTH (month, day, and year): Sept 12, 1864

7 AGE: Years 63 Months Days 6

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Custodian

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) ..... (State or country) Elk Neck, Md

PARENTS

10 NAME OF FATHER James R McCall

11 BIRTHPLACE OF FATHER (City or town) ..... (State or country) Elk Neck Md

12 MAIDEN NAME OF MOTHER Rebecca Myers

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Elk Neck Md

14 Informant Katie M. McCall

(Address) 1922 E. Madison St.

15 Filed ..... 19 .....

Registrar

NRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1926, to Sept 10, 1927, that I last saw h[im] alive on (Sept 2), 19 27, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted ~

If not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) John Davis M. D.

9/27. 1927 (Address) 936 Monument W

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Angel Hill Hare De Grace Md

Date of Burial aug 14 1927

20 UNDERTAKER Lee McGinnis & Son

ADDRESS 501 Walk St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25536

CERTIFICATE OF DEATH

90 E 25536

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE (No. [redacted] St., 3-5 Ward)

BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madelena Bucci

(a) RESIDENCE NO. 905 Fawn St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White Italian	Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dominck Bucci

6 DATE OF BIRTH (month, day, and year) September 15 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
68		11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER Ludro Ippolito

11 BIRTHPLACE OF FATHER (City or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Rosa Imbrone

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Celina Bucci

(Address) 905 Fawn St.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-1, 1927, to 9-7, 1927, that I last saw her alive on 9-6, 1927, and that death occurred, on the date stated above, at 9.00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted ?

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) C. Hamilton Bunch M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer	Sept 10 1927
20 UNDERTAKER	ADDRESS
Wendell Hyppd	Woodlawn

C. HAMILTON JONES, M. D.

SEP 13 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 25537

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25537

CERTIFICATE OF DEATH.

148

1-PLACE OF DEATH

City of BALTIMORE: (No. 55 N Caroline St St 6-9 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Smith

(a) RESIDENCE NO. 55 N Caroline St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rag Picker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Va

14 Informant John Smith

(Address) 55 N Caroline St

15 Filed_____, 19_____

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 4/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Pupural Eclampsia (7 mons preg)

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary)

(duration) yrs. mos. ds.

(Signed) J S Culley M. D.

(Coroner)

1/13/27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Jan 7 19 27

20 UNDERTAKER Wendell & Zappe ADDRESS 310 N Eden

Dth should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25538

CERTIFICATE OF DEATH.

90 E 25538

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen. Hospital WARD) 26

2-FULL NAME Charles Tenner

(a) RESIDENCE NO. 1420 E. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Soldier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927 to Sept 12, 1927

that I last saw him alive on Sept 12, 1927

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio-Vascular disease Decompensated

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ? yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam

(Signed) Louis T. Jaun, M. D.

9/12, 1927 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Hampton Rds Va Old Point Comfort

DATE OF BURIAL 9/14 1927

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

Spec.–7-17-26—A Co.—200 Bks.

E 25539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25539

+139

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen Hospital St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Amelia Leppo

(a) RESIDENCE-NO. Westminster Rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leppo

6 DATE OF BIRTH (month, day, and year): 8-6-1863

7 AGE — Years: 62 Months: 1 Days: 8

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): Retd

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co

(State or country) Md.

PARENTS

10 NAME OF FATHER Ed. Fredrigs

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Weise

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Hosp Records

(Address)

15 Filed SEP 14 1927 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14-27

17 I HEREBY CERTIFY, That I attended deceased from 8-30 1927 to 9-14 1927

that I last saw h.. alive on 9-14-27

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Intra muscular Abscess

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 0w ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman M. D.

(Address) Md. Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bauchman cemetery — Date of Burial: Sept 17 1927

20 UNDERTAKER: H Bankard & Son — ADDRESS: Westminster Md

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25540
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

#4 E 25540
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) #41 N. Fulton Ave (St.) 6-10 (Ward)

2-FULL NAME Edna Jane Ford.

(a) RESIDENCE No. #41 N. Fulton Ave St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22-1917.

7 AGE: Years 10 | Months 5 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School - Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS
10 NAME OF FATHER Calvert S. Ford.
11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.
12 MAIDEN NAME OF MOTHER Edna E. Lowsley
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Calvert S. Ford.
(Address) #41 N. Fulton Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to Sept 12, 1927, that I last saw h[illegible] alive on Sept 12, 1927, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac + Respiratory Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of tibia and fibula

(duration) 1 yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) H. E. Hellers, M. D.

Sept 13, 1927 (Address) 1301 4 Park pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Sept 15 1927

20 UNDERTAKER: Geo E. Miller & Son — ADDRESS: 2334 W. Balto St

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Ruoff.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25541

CERTIFICATE OF DEATH

46 E 25541

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

City of BALTIMORE: (No. ..... St., 6-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ruoff (Spelled)

(a) RESIDENCE NO. 1924 St. Gilmanton St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE: Years 52 Months ... Days ... IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ...

(State or country) Germany

PARENTS

10 NAME OF FATHER Herman Scheer?

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country) Germany

14 Informant Charles Ruoff

(Address) 2009 Eastern Ave

15 Filed ... 19 ... Registrar

SEP 14 1927 RUOFF

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/4, 1927, to 9/12, 1927, that I last saw h[illegible] alive on 9/12, 1927, and that death occurred, on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Contributory (duration) 1 yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ... yrs. 3 mos. ... da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Feb. 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) J. M. Hurt, M. D.

, 19 (Address) Balt. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem. Date of Burial Sept 15 1927

20 UNDERTAKER John Ellers ADDRESS 200 Orleans

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Marked.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25542

CERTIFICATE OF DEATH.

101-001

E 25542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame St 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Clemens Merkel

(a) RESIDENCE NO. Lisquitte St .ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct-1-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	76	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pittsburg Pa
(State or country)

PARENTS

10 NAME OF FATHER Francis Merkel

11 BIRTHPLACE OF FATHER (city or town) Bavaria
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Ray

13 BIRTHPLACE OF MOTHER (city or town) Bavaria
(State or country)

14 Informant Sister Mary Dionedes
(Address) Lisquitte St City

15 Filed ..... 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-12-1927

17

I HEREBY CERTIFY, That I attended deceased from Sept-9-, 1927, to Sept-12-, 1927,
that I last saw her alive on Sept-12-, 1927,
and that death occurred, on the date stated above, at 5-20-P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
Myocardial Insufficiency

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Seybert, M. D.

, 19 (Address) 1802 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Notch Cliff Rd.	Sept 15 1927
20 UNDERTAKER Frank A. Fink	ADDRESS 915 N. Gay St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25543

90 E 25543

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1039 Light St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jane Herget

(a) RESIDENCE NO. 1039 Light St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 9 mos. 23 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Herget

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1844

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	82	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew C. Miskimon

11 BIRTHPLACE OF FATHER (City or town) Baltimore, (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Easton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Md.

14 Informant Mary Emma Herget

(Address) 1039 Light St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 –, 19 27, to Sept 10 –, 19 27, that I last saw h[illegible] alive on Sept 9 –, 19 27 and that death occurred, on the date stated above, at 11.15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) – yrs. – mos. 1 ds.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. K. Duncan M. D.

, 19 (Address) 1340 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial Sept 14 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Lights

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 14 1927 Harry Jones M. D.

Spec.—12-0-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25544

1-PLACE OF DEATH

City of BALTIMORE: (No. 232 N Amity St. 18-26 (Ward)

2-FULL NAME Wealthy Johnson

(a) RESIDENCE NO. 232 N Amity St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTRATION NO. E 25544

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 Color or Race Col.

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willis Johnson

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1886

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
41	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rock Hall

(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Wesley Talbert

(Address) 232 N Amity St

15 Filed ..... 19..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Sept 11, 1927, that I last saw h..... alive on Sept 9, 1927, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulm. Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B.

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt. Auburn Cemetery Sept 15, 1927

20 UNDERTAKER — ADDRESS

Mrs. Katie R. Williams 1. Schroeder St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25545

CERTIFICATE OF DEATH.

100-001

E 25545

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4003 Edmondson Ave ST. 20-71 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald E. Wyatt

(a) RESIDENCE NO. 4003 Edmondson Ave ST. WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 14. 1927

7 AGE — Years: 0 Months: 1 Days: 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cumberland Md

PARENTS

10 NAME OF FATHER: Owen J. Wyatt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Elkington W. Va

12 MAIDEN NAME OF MOTHER: Beatrice V. Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Owen J. Wyatt
(Address): 4003 Edmondson Ave

15 Filed . 19 ... Registrar: R.H.C

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 9 . 1927 . to Sept 13 . 1927 .
that I last saw him alive on Sept 13 . 1927 ,
and that death occurred, on the date stated above, at 5.05 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Pneumonia (Broncho)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) George L. Wissig M. D.

. 19 (Address) 4004 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion. Frederick Co. Md — DATE OF BURIAL: Sept 15 1927.

20 UNDERTAKER: Mr & Mrs. John W. Teufel & Son — ADDRESS: 801 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Baugert.

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

E 25546

CERTIFICATE OF DEATH

E 25546

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen'l Hosp. St. 15-67 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie L. Baugert

(a) RESIDENCE NO. 3108 Walbrook Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 8 mos. 17 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel L. Baugert

6 DATE OF BIRTH (month, day, and year) Jan 27 - 1858

7 AGE: Years 69 Months 8 Days 17

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Jno A Hamilton

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Lansford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... C. E. ANDERSON-JONES, M. D. Registrar

Per .....

EP 14 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 9-5, 1927, to 9-13, 1927,

that I last saw h[illegible] alive on 9-13, 1927

and that death occurred, on the date stated above, at 4:55 a m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Postoperative cerebral hernia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-6-27

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) Jno A Hamilton, M. D.

, 19 (Address) 1100 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

Date of Burial Sept 15, 1927

20 UNDERTAKER W. H. Tickner & Son

ADDRESS Norfolk

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25547.

CERTIFICATE OF DEATH.

66

E 25547

1-PLACE OF DEATH

City of BALTIMORE: (No. 921 Leadenhall St. St. 23-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Johnson.(C)

(a) RESIDENCE NO. 921 Leadenhall St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. ------- mos. ---- ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	Colored	Married.

5a If married, widowed, or divorced (or) WIFE of Lawrence Johnson.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28	-------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Charles Chambles.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary --------(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant William Barnes.(C)

(Address) 921 Leadenhall St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 12, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

9/14 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waverly Virginia Date of Burial Sept 14 1927

20 UNDERTAKER S. L. Brown & Son ADDRESS 108 W Monty

American Adress, to va

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

ALICE SHULER

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25548

185 E 25548

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General Hospital St. 13-51 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Shuler

(a) RESIDENCE NO. 3108 Cedar Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Shuler

6 DATE OF BIRTH (month, day, and year): Oct 4 1847

7 AGE: Years 79 Months 11 Days 8

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): York Pa.

(State or country)

PARENTS

10 NAME OF FATHER: Jacob Shuler

11 BIRTHPLACE OF FATHER (City or town): ?

(State or country)

12 MAIDEN NAME OF MOTHER: ? Ferbick

13 BIRTHPLACE OF MOTHER (city or town): ?

(State or country)

14 Informant: Hospital Records

(Address)

15 Filed SEP 14 1927 19 Registrar

Per R M K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 8/23, 19 27, to 9-12, 19 27,

that I last saw h[illegible] alive on 9-12, 19 27,

and that death occurred, on the date stated above, at 2:40 P m.

The CAUSE OF DEATH was as follows:

Fractured left forearm

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Broncho pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? YES Date of 8/24/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Sept. 15 1927

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Walbrook Road

Note.—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Ethel J. Ross.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25549

CERTIFICATE OF DEATH.

186-003

E 25549

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2942 Hudson St. 1-1 Ward)

2-FULL NAME Ethel J. Ross

(a) RESIDENCE NO. 2942 Hudson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6th 1923

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.

(State or country)

PARENTS

10 NAME OF FATHER Chas T. Ross

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Ethel V. Oliver

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto, Md.

14 Informant Chas. T. Ross

(Address) 2942 Hudson St.

15 Filed 19

Per RLK Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Accident

Fracture of Skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

Signed G. E. Radue, M. D.

(Coroner)

19 (Address) 143 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Souder Park Cem. Date of Burial Sept. 15 1927

20 UNDERTAKER Lilly & Geiler ADDRESS 403 N. Wolfe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 25550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

123 E 25550

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp. St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Joseph A. Bolgiano

(a) RESIDENCE NO. 1909 E 30th St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Bolgiano

6 DATE OF BIRTH (month, day, and year) August 29 1861.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	66		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work accountant

(b) General nature of industry, business, or establishment in which employed (or employer) Packers

(c) Name of employer Swift & Co. Baltimore Md

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER John C. Bolgiano

11 BIRTHPLACE OF FATHER (City or town) Balto. Md

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Bucknmiller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.

(State or country)

14 Informant Mr. Joseph A. Bolgiano

(Address) 1909 E. 30th St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept. 13-27

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1927, to Sept 13, 1927, that I last saw him alive on Sept 13, 1927, and that death occurred, on the date stated above, at 4:20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic cholecystitis with Stones

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) few minutes yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Sept 1-27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Thomas C. Cullen M. D.

. 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — Date of Burial Sept. 15 1927

20 UNDERTAKER John B Spence — ADDRESS 1325 N. Carolina St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25551
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

179 E 25551
REGISTERED NO.

City of BALTIMORE: (No. 1114 W. Lanvale St. Ward 26)

2-FULL NAME Ivan M. Garrett

(a) RESIDENCE NO. 6512 Baltimore Ave St. Helena Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17 1910

7 AGE — Years: 17 — Months: 2 — Days: 27 — If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Bethlehem Steel Co.

9 BIRTHPLACE (city or town):

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John Garrett

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Alice Meyers

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Pennsylvania

14 Informant: John Garrett (Father)
(Address) 6512 Baltimore Ave

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns of body. (Accidental), (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Explosion of furnace. Bethlehem Steel Co. (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

1927 (Address) 2572 Edmondson Ave.

Sept 14, 27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Sept. 15 1927

20 UNDERTAKER: Henry Sander & Sons Inc. — ADDRESS: 1710 Fleet St

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 25552

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25552

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (1724) St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geneva Osborne

(a) RESIDENCE NO. 914 Druid Hill ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Branch

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Cecelia Hard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed SEP 14 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from August 9 27, 19..., to September 9 27, 19...,

that I last saw her alive on September 9 27, 19...,

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis,

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted Unknown

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path

(Signed) L. E. Madden, M. D.

9-9-, 1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Lawn Date of Burial Sept 10 27

20 UNDERTAKER Samuel Steinecky ADDRESS Woodlawn

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25553

CERTIFICATE OF DEATH.

E 25553

REGISTERED NO. 1594

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1258 (ST.) Glyndon Ave (WARD) 21-24

2-FULL NAME Christopher Dolan

(a) RESIDENCE NO. 1258 (ST.) Glyndon Ave (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10, 1927

7 AGE — Years — Months 3 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None yr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jas M Dolan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary A Haggerty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Jas M Dolan
(Address) 1258 Glyndon Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1927, to Sept 13, 1927,

that I last saw him alive on Sept 13, 1927,

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

9/14, 1927 (Address) 10 E N Butler Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL 9-15 1927

20 UNDERTAKER: T Bernard C Hale — ADDRESS 1000 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 14 1927

Spec.—1-10-21—M&T—1500 Bks.

E 25554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25554

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 W Saratoga St. 18-7th WARD)

2-FULL NAME Annie Gormley.

(a) RESIDENCE NO. 1215 W Saratoga St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: George Gormley.

6 DATE OF BIRTH (month, day, and year): March 14 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77.	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: F. J. Deckelmayer?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Mrs Bernice Deckelmayer (Address) 1215 W. Saratoga St.

15 Filed ..... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 1 1927 to Sept 14 1927, that I last saw her alive on Sept 13 1927, and that death occurred, on the date stated above, at 1345 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart trouble & General Dropsy.

(duration Some yrs. mos. ds.)

CONTRIBUTORY (Secondary) General Dropsy

(duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan, M. D.

Sept 14 1927 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chambersburg Corpus Christi Pa.

DATE OF BURIAL: Sept 16 1927

UNDERTAKER: John J Cowan & Son.

ADDRESS: 30 Holliday St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 25555 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25555

CERTIFICATE OF DEATH. 202

1-PLACE OF DEATH Maryland Penitentiary

City of BALTIMORE: (No. 9547 Forest St., 10-15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Ross

(a) Residence No. Thurston Md St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ross.

6-DATE OF BIRTH (month, day and year) June 5, 1903

7-AGE. 22 yrs. 3 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). Montgomery Co
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Joseph Ross

11-BIRTHPLACE OF FATHER (city or town)..? (State or Country),

12-MAIDEN NAME OF MOTHER, Mary Jane Leary

13-BIRTHPLACE OF MOTHER (city or town)..? (State or Country),

14- (Informant) William Henry Ross

(Address) 9547 Forest St

15- Filed ....., 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept 9 1927

17- I HEREBY CERTIFY, That I attended deceased from July 15 19 27 to Sept 9 19 27

that I last saw h. alive on Sept 9 19 27

and that death occurred, on the date stated above, at 1 7 m.

The CAUSE OF DEATH* was as follows:

1 Dislocation of 4th
Cervical vertebra
(Hanged by order of court)
(Duration) immediate yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. W. Edwards M. D.

, 19 (Address) 9547 Forest St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MA

DATE OF BURIAL, ... 19....

20-UNDERTAKER. Commissioner Health,

ADDRESS SEP 14 1927

C. HAMPSON JONES, M. D.

SEP 14 1927

instructions on back of certificates.

Cor.—12-5-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25556

CERTIFICATE OF DEATH.

161-001

E 25556

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 3-4 Ward)

2-FULL NAME Pearl" Stanley

(a) RESIDENCE NO. 316 S. Spring St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 6/27

7 AGE	Years	Months	Days	IF LESS than 1 day 3 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Dewey Stanley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Cambridge, Md.

12 MAIDEN NAME OF MOTHER Myrtle Horsey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Meeker's Neck, Md.

14 Informant Father

(Address)

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity (About 8 mons gestation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Ford Thomas M. D.

(Coroner)

9/9/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos. 3 hours ds. In the State 6 hours yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

JOHNS HOPKINS HOSPITAL SEP 14 1927

20 UNDERTAKER ADDRESS

Commissioner Health,

Per Wm. S. WORRALL

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

25557

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25557

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST. 9-18 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin R Bechtel

(a) RESIDENCE NO. 1819 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 9th 1927

7 AGE — Years — Months 5 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jacob H Bechtel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary J Ber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Jacob H Bechtel 1819 Aisquith St

15 Filed , 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1927, to Sept 14, 1927, that I last saw h[illegible] alive on Sept 14, 1927, and that death occurred, on the date stated above, at 3 00 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage Fontanel & Scalp

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical.

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: Sept 15th 1927

20 UNDERTAKER: George Schilling & Sons

ADDRESS: N 26 E Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25558

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25558

CERTIFICATE OF DEATH.

65-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Reinhart

(a) RESIDENCE NO. Mayor Ohio ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Andrew Reinhart

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER James Hatcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Blackenship

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1927

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1927, to Sept 14, 1927, that I last saw h... alive on Sept 14, 1927, and that death occurred, on the date stated above, at 6 15 m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ohio

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Biopsy

(Signed) Christopher Johnston, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Huntington W Va — DATE OF BURIAL 9/14/27

20 UNDERTAKER Joseph Ahrens — ADDRESS 721 Bway

THIS is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 25559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 25559

REGISTERED NO.

1-PLACE OF DEATH Brice's Shore

City of BALTIMORE: (No. Foot of Leadenhall St. 23-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Zentgraf,

(a) RESIDENCE NO. Foot of Leadenhall St. Ward

(Usual place of abode) Wife

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	61	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Brice Shipyard

9 BIRTHPLACE (city or town)

(State or country) Md.,

PARENTS

10 NAME OF FATHER Ignatious Zentgraf

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Roele

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Bertha F. Zentgraf,

(Address) 436 E Lanvale St.

15 Filed ..., 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept. 13, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 19 27, to Sept. 13, 19 27

that I last saw him alive on Sept. 13, 19 27

and that death occurred, on the date stated above, at 12.30 P.

The CAUSE OF DEATH* was as follows:

Chronic aortic regurgitation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) Jonny Kleibel, M. D.

9/14 19 27 (Address) 1224-1226 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: Sept. 15 19 27

20 UNDERTAKER Harry A. Witzke — ADDRESS 1534 W. Lanvale St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25560 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 25560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Jones

(a) RESIDENCE NO. 502 N. Bruce ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of mar. 12. 1885

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 42 Months 6 Days 1 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Repair

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chance md

PARENTS

10 NAME OF FATHER Asbury Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Blanche Jones (Address) 502 n Bruce st

15 Filed . . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 31 . 1927 . to Sept 13 . 1927 . that I last saw h[illegible] alive on Sept 13 . 1927 and that death occurred, on the date stated above, at 6:30 P m

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pulmonary tb.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Wm. P. Cohen . M. D.

. 19 (Address) West Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Deales Island md

DATE OF BURIAL 9/16 1927

20 UNDERTAKER Robert Brodeseson

ADDRESS Cor Calhoun Hollins st

THIS is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25561

CERTIFICATE OF DEATH.

181-001

E 25561

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 4206 Wrenwood Ave St. 27-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Grewe

(a) RESIDENCE NO. 4206 Wrenwood Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Grewe

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Hamburg, Germany

PARENTS

10 NAME OF FATHER Henry Grewe

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Germany

14 Informant Elizabeth Grewe

(Address) 4206 Wrenwood Ave

15 Filed_____, 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Dilatation

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Presence of Ill Gas-

accidental (duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Cotter, M. D.

(Coroner)

9/14/19 27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death____ yrs.____ mos.____ ds. In the State____ yrs.____ mos.____ ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakewood cemetery Date of Burial 9/15 1927

20 UNDERTAKER Robert Brookeson ADDRESS Calhoun & Hollins

Be sure to properly classified. Exact statement of OCCUPATIONS is of DEATHS in plain terms, so that it may be very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 25562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25562

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. Ward)

2-FULL NAME Solomon Holsey

(a) RESIDENCE NO. 1827 McCulloh St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 11 mos. Nos.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 28 - 1923

7 AGE: Years 3 Months 4 11 Days 15

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: John E. Holsey

11 BIRTHPLACE OF FATHER (city or town)

(State or country): So. Carolina

12 MAIDEN NAME OF MOTHER: Minnie Davis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): So. Carolina

14 Informant: John E. Holsey

(Address): 1827 McCulloh St.

15 Filed ..... 19 .....

ARA Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

2 hrs.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) accidental

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Kennedy M. D.

(Coroner)

19 27 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial 9/15/1927

20 UNDERTAKER: Mrs Geo. H. Holland — ADDRESS 1601 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25563 E 25563

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 Argyle Ave WARD) 7-24

REGISTERED NO. 1901.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathen A. Jackson

(a) RESIDENCE No. 1302 Argyle Ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min
	45	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Andrew Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Pinago

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Henrietta Jackson

(Address) 1302 Argyle Ave

15 Filed ....., 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1927

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to July 31, 1927, that I last saw deceased alive on July 30, 1927, and that death occurred, on the date stated above, at 1:10 A m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin Exam

(Signed) Paul C. Lehmann, M. D.

Aug. 1, 1927 (Address) 1302 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 8/6/1927

UNDERTAKER Wm. Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

THIS IS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

2 E 339

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25564

CERTIFICATE OF DEATH.

+ 84 E 25564

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Florence Biesecker

(a) RESIDENCE NO. Boswell Pa ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Inn Biesecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Elizabeth Cover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15

Filed , 19 RMK. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 26, 1927, to Sept 13, 1927,

that I last saw her alive on Sept 13, 1927,

and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, right cerebral glioma, non malignant

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Boswell, Pa.

Did an operation precede death? yes Date of Sept 10, 1927

Was there an autopsy? yes

What test confirmed diagnosis? yes autopsy

(Signed) J. Deryl Hart, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boswell Pa — DATE OF BURIAL 9/15/27

20 UNDERTAKER Joseph Ahern — ADDRESS 221 Bway

PRINT in very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E25565 HEALTH DEPARTMENT—CITY OF BALTIMORE E25565

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 610 W. Monty. St. 92-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Brown

(a) Residence No. 610 W. Monty. St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Brown

6-DATE OF BIRTH (month, day and year): June 1857

7-AGE: 70 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: —

(b) General nature of Industry, business, or establishment in which employed (or employer): HD

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Va

PARENTS.

10-NAME OF FATHER, Raymond Brown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Va

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), —

11- (Informant) Raymond Brown Bro.

(Address) 1017 Leadenhall St.

15- Filed ..... 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 14, 1927

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924 to Sept 14, 1927 that I last saw h[illegible] alive on Sept 13, 192[illegible] and that death occurred, on the date stated above, at 2:05, m.

The CAUSE OF DEATH* was as follows: Pneumonia Bron

(Duration)..... yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration)..... yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Physician's Opinion

What test confirmed diagnosis? None

(Signed) Thurlow H. Fowler M. D.

Sept 14, 1927 (Address) 712 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn DATE OF BURIAL, Sept 16, 1927

20-UNDERTAKER, L. S. Brown's Son ADDRESS 1[illegible] W. Monument St

Instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25566

CERTIFICATE OF DEATH.

129 E 25566

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 S. Green ST., 22-30 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary King

(a) RESIDENCE NO. 718 S. Green ST., 22 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William King

6 DATE OF BIRTH (month, day, and year) Dec 25, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
49	50	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of Indnstry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto; Md.

PARENTS

10 NAME OF FATHER Frank Divers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Matilda Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co. Md

14 Informant Mrs. King

(Address) 718 S. Green St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/13/1927

17

I HEREBY CERTIFY, That I attended deceased from 7/14, 1927, to 9/13, 1927,

that I last saw h Dr alive on 9/13, 1927,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Acute.

Pulmonary Hypostasis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Pharyngitis (duration) yrs. 1 mos. 30 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical History.

(Signed) W. R. E. Bishop, M. D.

, 19 (Address) 709 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL Sept 15 27

20 UNDERTAKER John H. Forden — ADDRESS 1027 Lombard

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25567

CERTIFICATE OF DEATH.

129 E 25567

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1011 Peach Alley. 23-31 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Gray.(C)

(a) RESIDENCE NO. 1011 Peach Alley. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ---------- How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Widower.

5a If married, widowed, or divorced, HUSBAND of XXXXXXXX Rose Gray.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	92	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Harry Gray.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Clara ------(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Robert Gray.(C nephew.

(Address) 1011 Peach Alley.

15 Filed SEP 15 1927, 19 _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 13, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) [signature] M. D.

(Coroner)

9/14 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial Sept 16 19 27

20 UNDERTAKER John H. Toadvine ADDRESS 1027 Druid Hill

If death occurred in a hospital or institution, or if the body is to be cremated, the certificate must be filled out in full. Otherwise, the Registrar may be required to withhold the permit for burial. Please write plainly with ink, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 25568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-002

E 25568

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (NO. 18-26 ST., WARD)

2-FULL NAME Margaret Ramey

(a) RESIDENCE NO. 839 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-4-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		6	9.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Waddell Ramey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C

12 MAIDEN NAME OF MOTHER Alice Henderson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Records
(Address) Johns Hopkins Hospital

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept 12, 19 27, to Sept 13, 19 27,
that I last saw h[illegible] alive on Sept 13, 19 27
and that death occurred, on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:

Meningitis, Influenzal

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of spinal fluid

(Signed) H. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct

DATE OF BURIAL Sept 15 19 27

20 UNDERTAKER C. A. Brodt Son

ADDRESS 101 W Monument

FEB 15 1927 C. WARD JONES, M.D.

Spec. -7-17-26—A Co.—200 Bks.

E 25569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 25569

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1102 S Second St. 16-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Roemer

(a) RESIDENCE NO. 1102 S Second St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Roemer

6 DATE OF BIRTH (month, day, and year) Feby 16 — 1850

7 AGE	Years	Months	Days
	77	6	29

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Sophia Roemer

(Address) 1102 S Second St

15 Filed ..... 19 .....

Registrar

SEP 15 1927 H. HOWARD JOYES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept 14 — 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept -6- , 1927, to Sept 14 , 1927.

that I last saw h.im alive on Sept 13 , 1927.

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chr. Arterio-sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. Davidson, M. D.

. 19 (Address) 2035 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schmucker

Date of Burial Sept 17 1927

20 UNDERTAKER John Ullrick

ADDRESS 2108 Aliceanna

Be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 25570

CERTIFICATE OF DEATH

E 25570

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 918 N Broadway St., 2-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Dasch

(a) RESIDENCE NO. 918 N Broadway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Jansen

6 DATE OF BIRTH (month, day, and year): August 24 1868

7 AGE: Years 73 Months ~~11~~ Days 19

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Butcher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Jacob Dasch

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Klaw

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Caroline Dasch

(Address): 918 N Broadway

15 Filed ..... 19 .....

Registrar

SEP 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 9 - 1927, to Sept 13 1927, that I last saw him alive on Sept 13 1927, and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Oedema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E Gill Hall, M. D.

Sept 14 1927 (Address) 1631 E. North av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

Date of Burial: Sept 16 1927

20 UNDERTAKER: John Ullrick

ADDRESS: 2108 Eden

Be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25571

CERTIFICATE OF DEATH.

16-00 E 25571

E 25571
1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 234 S Eden ST. 3-5 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Baranowski

(a) RESIDENCE NO. 234 S Eden ST, WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 10 1926

7 AGE: Years 1 | Months 6 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Felix Baranowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Bialobrzycki

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mrs. Bialobrzycki
(Address) 234 S Eden 2nd

15 Filed . . . . 19 . . . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/14 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/14, 1927, to 9/14, 1927, that I last saw h[illegible] alive on . . , 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Kardow, M. D.
9/15, 1927 (Address) 1918 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: Sept 15 1927

20 UNDERTAKER: J W Ozarowski — ADDRESS: 1950 Eastern

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25572

CERTIFICATE OF DEATH

90 E 25572

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Sinclair + Lowney Lane St. 816 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Soeder

(a) RESIDENCE NO. Sinclair + Lowney Lane St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late George L Soeder

6 DATE OF BIRTH (month, day, and year): Nov 29 1841

7 AGE: 85 Years 86 | Months 9 | Days 15 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs Anna Schatz.

(Address): Sinclair + Lowney Lane.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1927, to Sept 13th, 1927, that I last saw h alive on Sept 13, 1927, and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical signs + Symptoms

(Signed) Edwin H Benson M. D.

9/15, 1927 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Lawn. Date of Burial: Sept 16 1927

20 UNDERTAKER: Geo J Ruth ADDRESS: 1735 Hanford

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25573

CERTIFICATE OF DEATH.

74-001 E 25573

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Turner

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificates. FAILURE TO STATE OCCUPATION IS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 13th 1841

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	86	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER William Turner

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Ellen Aberle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Little Sisters of the Poor

(Address)

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Sept 13th

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..... to ....., 19.....,

that I last saw h.. alive on Sept 11, 1927,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Warner, M. D.

Sept 17, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Date of Burial: Sept-16 1927

20 UNDERTAKER: Rita Wiedefeld ADDRESS: 914 Fremont Ave

SEP 19 1927 HAMDEN-JONES CO.

Cor.—12-9-25—A Co.—200 Bks.

E 25574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7-18-003

E 25574

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.) Jonson

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Mun. Hosp. St. 12-49 (Ward)

2-FULL NAME Clara M. Lang

(a) RESIDENCE NO. 602 Regester St. St. 602 Regester Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard H. Lang.

6 DATE OF BIRTH (month, day, and year) Sept. 22 1883

7 AGE Years 43 Months 11 Days 20 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md

PARENTS

10 NAME OF FATHER John Chapman

11 BIRTHPLACE OF FATHER (city or town) Balto. Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Hillegas

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md

(State or country)

14 Informant Richard H. Lang

(Address) 602 Regester Ave

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc

Fracture of Skull

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. ..... ds.

Signed F. C. Blades M. D.

(Coroner)

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Date of Burial Sept 15 1927

20 UNDERTAKER George Schmidt ADDRESS Madison & Pratt

very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

E 25575 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 E 25575

REGISTERED NO.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Cathedral & Fayette St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Agnes Byrne

(a) RESIDENCE No. 305 N. Gay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Edward A Byrne

6 DATE OF BIRTH (month, day, and year) April 10 1863

7 AGE Years 64 Months 5 Days 4

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Patrick Myler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Talbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary A Byrne (Address) 305 N Gay St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1927

17 I HEREBY CERTIFY, That I attended deceased from August 4 , 1927 , to September 14 1927 ;

that I last saw her alive on September 14 , 1927 ;

and that death occurred, on the date stated above, at 2:10 A. m.

The CAUSE OF DEATH* was as follows:

1a Fractured Neck of Femur

1b Hypostatic Pneumonia Complicating Fracture of Neck of Femur (Right).

Chair turned over when trying to get up

(duration) yrs. mos. days

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) W. W Wacker M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral County DATE OF BURIAL Sept. 17 1927

20 UNDERTAKER Geo L Keith ADDRESS 1735 Harford ave

THION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25576

CERTIFICATE OF DEATH.

16-001

E 25576

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2518 Mosher St. 16-68 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Amelia Kietrich

(a) RESIDENCE NO. 2518 Mosher ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17 27.

7 AGE — Years: — Months: — Days: 3 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Wm Kietrich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Rebecca Ruth Miller Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: The Father

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1927, to Sept. 15, 1927, that I last saw h[illegible] alive on Sept. 14, 1927, and that death occurred, on the date stated above, at 2-40 a m.

The CAUSE OF DEATH* was as follows:

Congenital Debility or Insufficient maturity at birth.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) A. Stans M. D.

, 19 (Address) 1215 Harlem St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Sept 16 1927

20 UNDERTAKER: Harry W. Eden

ADDRESS: Mt Washington

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25577

CERTIFICATE OF DEATH

90 E 25577.

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto. City Hospitals St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Edw.~~ Waters, Edward N

(a) RESIDENCE NO. None St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug - 19th 1857

7 AGE 70 Years Months Days 25 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Joshua Waters

11 BIRTHPLACE OF FATHER (City or town) [illegible]

(State or country) U.S.A. Maryland

12 MAIDEN NAME OF MOTHER Rebecca A. Ferris

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md. USA

14 Informant A. M. Zell

(Address) 1013 Garrison Ave.

15 Filed SEP 15 1927 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14 1927

17 I HEREBY CERTIFY, That I attended deceased from 12-30, 1909, to 9-14, 1927,

that I last saw him alive on 9-14, 1927,

and that death occurred, on the date stated above, at 505 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 17 yrs. mos. ds.

CONTRIBUTORY (Secondary) arterio-sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) C. Sheldon Boyle, M. D.

19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — Date of Burial Sept 15 1927

20 UNDERTAKER W. Cook — ADDRESS 527 E. Monument

very important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Blks.

E 25578 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 E 25578

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-12 WARD)

2-FULL NAME Louis Rudick

(a) RESIDENCE NO. 847 N. Milton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced, ~~(write~~ the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-13-26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) N. Y. Canal

PARENTS

10 NAME OF FATHER Louis Rudick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dorothy Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents — (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .. RHL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 4 , 1927, to Sept 12 , 1927, that I last saw h[illegible] alive on Sept. 12 , 1927, and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Dysentery - bacillary

(duration) ..... yrs. ..... mos 28 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood and mucus in stool

(Signed) Allan Blackman, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's, Hamilton — DATE OF BURIAL Sept 16 1927

20 UNDERTAKER J E Cook — ADDRESS 502 E Baltimore

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 25579

CERTIFICATE OF DEATH.

E 25579 PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 2324 McCollok St. 13-59 Ward)

2-FULL NAME Mary M Hett

(a) RESIDENCE NO. 2324 McCollok St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Hett

6 DATE OF BIRTH (month, day, and year) Jan 1860

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
67	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Roberts

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Etta Roberts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Bernard Hett

(Address) 2324 McCollok St

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 10 1927 to Sept 12, 1927,

That I last saw h.. alive on Sept 12, 1927,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Indefinite (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E Edward Fisher, M. D.

9-13 1927 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Date of Burial Sept 15 1927

20 UNDERTAKER John H. Soader ADDRESS 1027 Lond Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

113

E 25580

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO. E 25580

City of BALTIMORE; (No. 948 Saratoga St. 18-26 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jessie D. C Laney

(a) RESIDENCE NO. 948 Saratoga St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	Colored	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) nov. 18, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		9 mo.	26.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Daniel Chaney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) St Mary Co. Md.

12 MAIDEN NAME OF MOTHER Lola Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Henderson, N. C.

14 Informant William Daniel Chaney

(Address) 948 W. Saratoga St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

The post and from the evidence obtained by me

(Autopsy or inquiry)

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Gastro enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) E L Laughon

(duration) yrs. mos. ds.

Sept 15 1927 (Signed) J C Hales M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lion Cemetery Date of Burial Sept 15, 1927

20 UNDERTAKER Mrs Katie R. Williams ADDRESS 322 N. Edwards St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

D 25581 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25581

CERTIFICATE OF DEATH. 38

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-19 WARD)

2-FULL NAME Joseph Jones

(a) RESIDENCE NO. 432 Federal St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	Col-	Married

5a If married, widowed, or ~~divorced~~ HUSBAND of ~~or WIFE of~~ Lessie - Jones -

6 DATE OF BIRTH (month, day, and year) 3-11- 79

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wyatt Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Betty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia -

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 9 .1927. to Sept 13 .1927.

that I last saw h[illegible]live on Sept 13 .1927.

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Aortic insuff. Myocardial insuff.

Terminal Bronchopneumonia.

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Syphilis (duration) - yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X ray.

(Signed) Lyman Wilbur M. D.

Sept 13 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept. 15, 1927
20 UNDERTAKER Mrs R.A. Elliott	ADDRESS 1725 Washington

Spec.—1-12-23—M&T—500 Bks.

E 25582 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25582

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 Carlisle Place WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gloria Oliver

(a) RESIDENCE NO. 1729 Carlisle Place ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced (Husband of or) WIFE of Lloyd Oliver

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	about 38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Lloyd Oliver husband 1729 Carlisle Place

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to Sept 13, 1927, that I last saw h alive on Sept 12, 1927, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) about yrs. 1 mos. ds. according to history

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

, 19 (Address) 1729 Carlisle Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Sept. 15 1927

20 UNDERTAKER Mrs. Pete Cooper — ADDRESS 1725 Washington Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25583

CERTIFICATE OF DEATH

129 E 25583

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Franklin Square 2424 Hospital (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis M. Barker

(a) RESIDENCE NO. 820 Carroll St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mary A. Barker

6 DATE OF BIRTH (month, day, and year): Jan 26 - 1878

7 AGE: Years 49 Months 1 Days 17

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): 034

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Washington D. C.

PARENTS

10 NAME OF FATHER: John P. Barker

11 BIRTHPLACE OF FATHER (City or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Laura Canadacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimor Md

14 Informant (Address): Mary A. Barker 820 St Peter Street

15 Filed ..... 19 ..... Registrar

SEP 15 1927 RMH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from March 30 1927, to Sept 13 1927, that I last saw h— alive on Sept 12 1927, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Infants Abscess

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary): Anaemia

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lewis Emerson, M. D.

9/14 1927 (Address) 517 Lenox

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — Date of Burial: Sept 16 1927

20 UNDERTAKER: William Cook Co. — ADDRESS: 502 North Ave

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-25—M&T—500 Bks.

25584 HEALTH DEPARTMENT—CITY OF BALTIMORE. 10-C 25584

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 26-2 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Schmidt-

(a) RESIDENCE No. 3413 E. Lombard St ST. 26 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 21, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min
	4	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Schmidt-

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Matilda Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. John Schmidt-

(Address) 3413 E Lombard St

15 Filed SEP 19 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1927, to Sept 17, 1927, that I last saw her alive on Sept 17, 1927 and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Tonsillar + Pharyngeal Diphtheria

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Bac. Cult.

(Signed) Myron S. Miller, M. D.

9/18, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Sept 19th 1927

20 UNDERTAKER Lilly + Zeiler

ADDRESS 4033 Wolfe

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25585

CERTIFICATE OF DEATH.

159 E 25585

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2581 Frederick Ave ST. 21-64 WARD)

2-FULL NAME Baby Stobeck

(a) RESIDENCE NO. 2581 Frederick Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9/14-27

7 AGE — Years | Months | Days | If LESS than 1 day, ... hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Stobeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jennie Mohler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant .....

(Address) .....

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/14, 1927, to 9/14, 1927, that I last saw him alive on 9/14, 1927, and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Monstrosity

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Craniorachischisis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas A Cullen M. D.

9/14 1927 (Address) 210 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

1707 OPH

SEP 1 1927

TION IS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25586 E 25586

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 16209

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 816 Shamp ST. W-3 WARD)

2-FULL NAME Baby Webb

(a) RESIDENCE NO. 816 Shamp ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 12 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Webb

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Melvina Bond

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Melvina Webb
(Address) 816 Shamp st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 12, 1927, to Sept 14, 1927, that I last saw h[illegible] alive on Sept 14, 1927, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery
(6½ months)

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D H Hanover, M. D.

(Address) 605 Shamp st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

SEP 1 1927

Spec.–7-17-26—A Co.—200 Bks.

E 25587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 25587

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. ... St. ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Dialer

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years: 60 Months: Days: IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oyster shucker

(b) General nature of industry, business, or establishment in which employed (or employer): 049

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records UNIVERSITY OF MARYLAND

15 Filed ..., 19 ...

Registrar

1709 Orfila

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12/1927.

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1927 to Sept. 12, 1927, that I last saw him alive on Sept. 12, 1927 and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

arteriosclerosis

(duration) ... yrs. 8 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted ?

If not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Gen. Symptoms

(Signed) C. Hudson Wright, M. D.

..., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ... Date of Burial ... 19

20 UNDERTAKER Commissioner Health ADDRESS SEP 15 1927

very important. See instructions on back of certificates. LAST statement of OCCUPATION IS

Spec.–7-17-26—A Co.—200 Bks.

E 25588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 25588

1-PLACE OF DEATH

REGISTERED NO.

BALTIMORE CITY HOSPITALS

City of BALTIMORE: (No. ... St. ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Slade

(a) RESIDENCE NO. 913 S. Bannaders Street Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Reuds.

15 Filed ..., 19 ...

1714 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12/ 1927

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1926, to Sept. 12, 1927

that I last saw him alive on Sept. 12, 1927

and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Impaired diabetic chronic acidity, hypertension, cutaneous uric

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical, Sub

(Signed) C. Sheldon Berg, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ... Date of Burial ... 19

20 UNDERTAKER Robert E. Williams ADDRESS 1573 N.

BALTIMORE CITY HOSPITALS

SEP 13 1927

very important. See instructions on back of certificate. ... statistics. Each statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25589 E 25589

CERTIFICATE OF DEATH

38

25589

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS Ward)

2-FULL NAME George [illegible] 48-29

(a) RESIDENCE NO. 960 Orleans St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): ?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 39 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) North Carolina

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town):

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) ?

14 Informant

(Address) [illegible]

15 Filed , 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1927 to Sept. 11, 1927

that I last saw him alive on Sept. 11, 1927

and that death occurred, on the date stated above, at 6:00 A. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

Myocardial insufficiency

Syphilis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General & Sero

(Signed) C. Holmes Boyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND Date of Burial SEP 15 1927

20 UNDERTAKER: Commissioner Health. ADDRESS

Per Wm E WOODALL

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25590

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4000 Liberty Heights Ave ST. 28-4 WARD)

2-FULL NAME Katherine Raleigh Brooks

(a) RESIDENCE NO. 4396 Kathland Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Charles Albert Brooks

6 DATE OF BIRTH (month, day, and year): Feby 14/1859

7 AGE — Years: 68 — Months: 7 — Days: 1 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Hoziah Bromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louisa Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Edna A Staples

(Address): 4306 Kathland Ave

15 Filed ..... 19 .....

5 1927 C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1927, to Sept 15th, 1927, that I last saw her alive on Sept 14th, 1927, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Angina Pectoris

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C Hamilton Jones, M. D.

, 19 (Address) 2 W Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Sept 17 1927

20 UNDERTAKER: Harry A Arnaout

ADDRESS: 4214 Ridgewood Ave

Spec.—1-12-23—M&T—500 Bks.

E 25591

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25591

CERTIFICATE OF DEATH.

REGISTERED NO. 73

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. ST. 27-42 WARD

2-FULL NAME John Carroll

(a) RESIDENCE NO. 208 Locust Ave., ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electric Work

(b) General nature of industry, business, or establishment in which employed (or employer) Electrician

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Moses Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Mc Guan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs P. Byrnes
(Address) Berger, Md

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/13th/27 19

17 I HEREBY CERTIFY, That I attended deceased from 9/11/27, 19, to 9/13/27, 19, that I last saw him alive on 9/13/27, 19, and that death occurred, on the date stated above, at 1:38 P. m.

The CAUSE OF DEATH* was as follows:

Bulbar Paralysis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) A Lawrence Fahney, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Sepulchre

DATE OF BURIAL 9/16 19 27

20 UNDERTAKER J. A. Moran

ADDRESS 320 E. Baltimore

Spec.—1-12-23—M&T—500 Blks.

E 25592

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25592

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 13-57 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Hale

(a) RESIDENCE NO. 3643 Maple Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-6-26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Milton Hale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 5, 1927, to Sept 14, 1927, that I last saw her alive on Sept 14, 1927, and that death occurred, on the date stated above, at 3:20 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery - bacillary

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood and microscopical

(Signed) Allen Brown, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Carrollton	Sept 16 1927

20 UNDERTAKER Chenoweth & Son ADDRESS 3417 Chestnut Ave

Spec.—1-12-23—M&T—500 Bks.

E 25593

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25593

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 17-N WARD)

2-FULL NAME Beedie Gaston

(a) RESIDENCE NO. 820 Peirce St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of or WIFE of Richard Gaston

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) South Carolina

10 NAME OF FATHER Milliken Guarrells

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Reuels (Address) Johns Hopkins Hospital

15 Filed Sept 27, 1927 ARB Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1927, to Sept. 12, 1927, that I last saw h[illegible] alive on Sept. 12, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uremia, Chronic Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? B. Chem.

(Signed) Lyman Meiks, M. D.

9/12 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lem Cemetery DATE OF BURIAL Sept 15, 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St

Spec.—1-10-21—M&T—1500 Bks.

E 25594

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25594

CERTIFICATE OF DEATH.

REGISTERED NO. 177

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square Hosp.

CITY OF BALTIMORE: (No. 102 N Caro[illegible] ST. 14-27 WARD)

2-FULL NAME Dorothy TERRY

(a) RESIDENCE NO. 1517 W. SARATOGA ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 16, 1[illegible]

7 AGE 1 Years 10 Months 28 Days 27

If less than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Peter Terry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mabel Carothers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mabel Terry (Address) 1517 W Saratoga St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1927

I HEREBY CERTIFY, That I attended deceased from Sept. 13 .1927. to Sept. 13 .1927.

that I last saw h[illegible] alive on Sept. 13 .1927,

and that death occurred, on the date stated above, at 6:45 P m.

17 CAUSE OF DEATH* was as follows:

Ptomaine Poisoning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1517 W. Saratoga St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) [illegible] M. D.

. 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion — DATE OF BURIAL Sept 16 1927

20 UNDERTAKER John H. Jordan — ADDRESS 1027 Eutaw Pl

Spec.—1-10-21—M&T—1500 Bks.

E 25595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1929

E 25595

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 929 Leadenhall ST. (WARD) 23-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Pitts

(a) RESIDENCE NO. 929 Leadenhall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Pitts

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 60	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomack Co. Va.

PARENTS

10 NAME OF FATHER Raymond Bevans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomack Co. Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Frederick Pitts (Address) 929 Leadenhall St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 31, 1927, to Sept 13, 1927, that I last saw h alive on Sept 12, 1927, and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. ? mos. 3 ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Manifestations

(Signed) D. H. Campbell, M. D.

1927 (Address) 805 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Sept 16 19 27

20 UNDERTAKER John N. Joadrim — ADDRESS 1027 Hanover St

1927 C. HAMPTON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25596

90 E 25596

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 8 N. Calhoun St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Croxson Walsh

(a) RESIDENCE NO. 8 N. Calhoun St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 8 mos. 17 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of J. Yates Walsh

6 DATE OF BIRTH (month, day, and year) Dec 24, 1847

7 AGE	Years	Months	Days
	79	8	17

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Pierre A. Croxson

11 BIRTHPLACE OF FATHER (City or town)
(State or country)

12 MAIDEN NAME OF MOTHER Fanny Lincoln Ward

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs. Emily A. Mayo
(Address) 8 N. Calhoun St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1927, to Sept 14, 1927, that I last saw h[illegible] alive on Sept 13, 1927, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Dilatation

(duration) yrs. 1 mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Barnett C. Brown Callen, M. D.

19 (Address) 1404 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Lawn Cemy

Date of Burial Sept 19 27

20 UNDERTAKER John C. Mitchell & Sons

ADDRESS 19 E Eutaw St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 25597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25597

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Augusta Ave ST. 170 WARD 21)

2-FULL NAME Kunigunda Bochum

(a) RESIDENCE No. 417 Augusta Ave ST., 20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Bochum

6 DATE OF BIRTH (month, day, and year) May 24-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Ament

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Karg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs C Bochum

(Address) 417 Augusta Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to Sept 13, 1927, that I last saw h[illegible] alive on Sept 13, 1927, and that death occurred, on the date stated above, at 8.05 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/13, 19 27 (Address) 22 W Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Sept 16-1927

20 UNDERTAKER H. Brauning Son — ADDRESS 517 N Eutaw St

Spec.—1-12-23—M&T—500 Blks.

E 25598 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25598

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Newington ST. 19 WARD) 56

2-FULL NAME Rebecca Mich

(a) RESIDENCE NO. 802 Newington ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Solomon Mich

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant B Green 802 Newington ave (Address)

15 Filed SEP 16 1927, 19 RKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1927, to Sept. 15, 1927, that I last saw h alive on Sept. 15 1927, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs and Symptoms

(Signed) Harry M Rabenstal, M. D.

Sept 16 1927 (Address) 3704 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 9/16 1927

20 UNDERTAKER Jack Lev[illegible] 4139

ADDRESS Elliott

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25599

CERTIFICATE OF DEATH.

E 25599

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 46 So. Carrollton Ave) St. (16) Ward

2-FULL NAME Matilda Dubansky

(a) RESIDENCE NO. 46 So. Carrollton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1901

7 AGE: About 16 Years — Months — Days — IF LESS than 1 day.....hrs. or.....min.,

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Worker in Cotton Shop

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Lithuania

PARENTS

10 NAME OF FATHER David Dubansky

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Leah Lecka

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithuania

14 Informant (Address) Martin Dubansky 16 N. Va. Ave

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14, 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest, autopsy or inquiry) thereon and from the evidence obtained (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Inhaling Illuminating Gas

Dead when found

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed Thos. B. Norton M. D.

(Coroner)

15 1927 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. †See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial: 9/16 1927

20 UNDERTAKER: Jack Louis — ADDRESS: 1439 E. Baltimore

Very Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 25600

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25600

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 318 S. Gilmor St., 19-28 Ward) Registered No.

2-FULL NAME None (Six months Fortus) Baby Hemp (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 318 S. Gilmor St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 15-1927

7-AGE. ... yrs. ... mos. ... ds. If LESS than 1 day, about ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), 318 S. Gilmor St.

PARENTS

10-NAME OF FATHER, Frederick G. Hemp

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Hilda C. Adams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Havredegrace Md

14- (Informant) Mrs. Hilda C. Hemp
(Address) 318 S. Gilmor St.

15-

Filed ... 192 ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 15 27

17- I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1927 to Sept 15, 1927 that I last saw her alive on Sept 15, 1927 and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Nuckols M. D.

, 19 (Address) 130 S. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Maine Cemetery — DATE OF BURIAL: Sept. 16, 1927

20-UNDERTAKER: George L. Schwartz — ADDRESS: 2101 Eutaw Ave

CHARLTON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25601

CERTIFICATE OF DEATH.

E 25601

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St. 4-7 Ward)

2-FULL NAME Samuel Corbin

(a) RESIDENCE NO. Westminster Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: About 62 | Months: I don't Know | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boss - unloading

(b) General nature of industry, business, or establishment in which employed (or employer): Corn - at Cannery

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Joshua? Corbin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mc Ryan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs Corbin (wife)

(Address)

15 Filed_____, 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 - 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull - Caused by Injuries Sustained when he had a accident.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

(Signed) W. J. Cahn M. D.

(Coroner)

Feb 13, 1927 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Md — Date of Burial: Sept 15 1927

20 UNDERTAKER: H Bankard & Son — ADDRESS: Westminster Md

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25602

CERTIFICATE OF DEATH.

31 E 25602

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway St. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A. Hartman

(a) RESIDENCE NO. 700 Ramsay st ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Hartman

6 DATE OF BIRTH (month, day, and year) Oct 8. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Employee

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William A. Hartman (Address) 637 Bartlett Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1927, to Sept 14, 1927, that I last saw h alive on Sept 14, 1927 and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Tuberculosis, pulmonary (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical exam. & X-ray

What test confirmed diagnosis?

(Signed) George B Buell, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Sept 17, 1927

20 UNDERTAKER Wm Tucker Sons ADDRESS North & Pa

SEP 16 1927

Spec.–7-17-26—A Co.—200 Bks.

E 25603

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25603

CERTIFICATE OF DEATH

151

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1148 N Gay St. Ward) 27-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Smith

(a) RESIDENCE NO. 1148 N Gay St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 10 mos. 25 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Chas E Smith

6 DATE OF BIRTH (month, day, and year): Oct 20 1850

7 AGE — Years: 76 Months: 10 Days: 25 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore (State or country): Md

PARENTS

10 NAME OF FATHER: Edward A Smith

11 BIRTHPLACE OF FATHER (City or town): Baltimore (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Barroll

13 BIRTHPLACE OF MOTHER (City or town): Baltimore (State or country): Md

14 Informant: Chas E Smith (Address) 1148 N Gay St

15 Filed ..... 19 ..... RMK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1927 to Sept 15, 1927, that I last saw h[illegible] alive on Sept 15, 1927, and that death occurred, on the date stated above, at 9 AM m.

The CAUSE OF DEATH* was as follows:

Cardiac Nephritis

Uremia

Coma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) 12 hrs yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 9/13/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos A Wiseman M.D.

, 19 (Address) 1148 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem. Date of Burial: Sept 17 1927

20 UNDERTAKER: W M Tickner Sons ADDRESS: North Ave

very important. See instructions on back of certificates. ... STATE STATEMENT OF OCCUPATION IS

Spec.–7-17-26—A Co.—200 Bks.

25604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11 E 25604

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3404 Esther St. 76-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Balling

(a) RESIDENCE NO. 3404 Esther Pl. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1 26

7 AGE Years 10 Months Days 14

If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Julius J. Balling

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Marie Fischer

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Julius J. Balling

(Address) 3404 Esther St.

15 Filed ....., 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15-27

17 I HEREBY CERTIFY, That I attended deceased from Sept 9-27, 19..., to Sept 15-27, 19...

that I last saw h... alive on Sept 15-27, 19...

and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Cystic Colitis

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 7 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis?

(Signed) H. J. Hemmeter, M. D.

19 (Address) 1710 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

Date of Burial 9/17 19 27

20 UNDERTAKER Philip Henry

ADDRESS 2046 Orleans St

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25605
1-PLACE OF DEATH

+E 25605
REGISTERED NO.

City of BALTIMORE: (No. 407 N. Glover St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Wm Schaeffer

(a) RESIDENCE NO. 407 N. Glover St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Veronica Schaeffer

6 DATE OF BIRTH (month, day, and year): Jan 6 83

7 AGE — Years: 44 Months: 8 Days: 7

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 050

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: John Schaeffer

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: Catherine Thomas

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Veronica Schaeffer

(Address) 417 N. Glover St

15 Filed.....19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13/27

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 19 27 to Sept 12 19 27

that I last saw him alive on Sept 12 19 27

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(Primary)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary): acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Insurgent

Did an operation precede death? Yes Date of July 29

Was there an autopsy? Co.

What test confirmed diagnosis?

(Signed) J. Phil Younker M. D.

(Address) 501 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk — Date of Burial: Sept. 16 19 27

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25606

CERTIFICATE OF DEATH.

1927 E 25606

1-PLACE OF DEATH

City of BALTIMORE: (No. 709 W Lombard 24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Daniellus

(a) RESIDENCE NO. 709 W Lombard St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No. 1879

6 DATE OF BIRTH (month, day, and year)

7 AGE	48 Years	— Months	— Days	IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Factory
(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania
(State or country)

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithvania

14 Informant Anna Danielus
(Address) 709 W Lombard St.

15 Filed 19
SEP 16 1927
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH was as follows:*

Gun Shot of Chest (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Sept. 17. 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S Paca St.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bk

Cor.—12-9-25—A Co.—200 Bks.

E 25607

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 170 E 25607

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 709 W Lombard St., Ward)

2-FULL NAME Anthony Danielus

(a) RESIDENCE NO. 709 W Lombard Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No 1877

7 AGE 50 Years — Months — Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Talor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania (State or country)

PARENTS

10 NAME OF FATHER M. Danielus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Liyhvania

14 Informant Anna Danielus (Address) 709 W Lombard St.

15 Filed....., 19.....

RPCK Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Gunshot Head Suicide

Stock

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Secondary) (duration) yrs. mos. ds.

, 19 (Address) 143 W Fayette (Corone...) M. D.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Sept. 17. 1927

20 UNDERTAKER John Grebliauckas ADDRESS 1423 S Paca St.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25608

CERTIFICATE OF DEATH.

1944

E 25608

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 7-4 WARD)

2-FULL NAME Mr. Georg Fisher

(a) RESIDENCE NO. 125 S. Wolfe ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Fisher

6 DATE OF BIRTH (month, day, and year): Aug. 3/1852

7 AGE: Years 75 Months 1 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Frank Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Kunigunde Slade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Elizabeth Prasth

(Address) 125 S. Wolfe st.

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-15 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Sept 15, 1927, that I last saw h[illegible]live on Sept 15, 1927, and that death occurred, on the date stated above, at 9 10 p.m.

The CAUSE OF DEATH* was as follows:

Chr. Cardio Vascular Renal Disease

(duration) 15 yrs mos ds.

CONTRIBUTORY (Secondary): Senile exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Laurence Fehrney, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Sept 19 1927

20 UNDERTAKER: Jos. J. Kerr 156 N. ADDRESS: Luzerne

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001

E 25609
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 25609
REGISTERED NO.

City of BALTIMORE: (No. Sinai Hospital St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Levy

(a) RESIDENCE NO. 2440 Woodbrook Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) London England

PARENTS

10 NAME OF FATHER Ladis Levy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Rheen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Rebecca Levy
(Address) 2440 Woodbrook Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
September 15, 1927

17

I HEREBY CERTIFY, That I attended deceased from August 29, 1927, to September 15, 1927, that I last saw him alive on September 15, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted
If not at place of death? Baltimore, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood examination

(Signed) Hulton Henry, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Eisenberg Louis M. Eisenberg

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25610

CERTIFICATE OF DEATH.

~~25610~~ 1644

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2247 Eutaw St., 11-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Miller

(a) RESIDENCE NO. 2247 Eutaw St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Miller

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years 45 | Months — | Days — | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Maker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant: Charles Miller

(Address) 2247 Eutaw St

15 Filed ....., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/15/1927

17 I HEREBY CERTIFY, That I attended deceased from 9/14/1927 to 9/15/1927

that I last saw her alive on 9/15/1927

and that death occurred, on the date stated above, at 1089 m.

The CAUSE OF DEATH* was as follows:

Heart Exhaustion

CONTRIBUTORY (Secondary) Cerebral hemorrhage (duration) yrs. mos 3 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen L Davis, M. D.

, 19 (Address) 1727 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Sept 17 1927

20 UNDERTAKER: Wm H Easton — ADDRESS: Balto

Cor.—12-9-25—A Co.—200 Bks.

E 25611

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25611

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Steamer State of Virginia,

City of BALTIMORE: (No. Bay Line Pier, Light St Wharf. Ward)

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Battee.

(a) RESIDENCE NO. 915 Gorsuch Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 9 mos. 8 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of XXXXXXXXXXXX Margaret M. Battee.

6 DATE OF BIRTH (month, day, and year) December 6, 1859.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Bay Line S/S Co.

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Battee.

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Wolf.

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland.

14 Informant George Battee. (son)

(Address) 915 Gorsuch Ave.

15 Filed _____ 19 _____ Registrar

SEP 16 1927 Per R. W. K.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 14, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Head and neck crushed by a descending elevator on Smr. State of Virginia.

Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

(Signed) _____ M. D.

(Coroner)

9/15 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. Date of Burial 9/16 1927

20 UNDERTAKER E. Fran McCully ADDRESS 130 E. Fay

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25612 — 93 E 25612

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St. 4-25 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME George E. Weed

(a) RESIDENCE NO. 643 Vine St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (Write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 3 1888

7 AGE: Years 39 Months 7 Days 10 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steward

(b) General nature of industry, business, or establishment in which employed (or employer): Drug Co

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Geo Weed

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Fannie Taylor

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Fannie Taylor (Address) 643 Vine St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Gangrene

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Exhaustion

(duration) yrs. mos. ds.

(Signed) W. S. Purdy M. D.

Dec 15, 1925 (Coroner) (Address) 1037 Eutaw Medical Examiner Crabs.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem Date of Burial Dec 17 25

20 UNDERTAKER: Samuel Hensley ADDRESS 57 N Bdle

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25613 +47 E 25613

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Wallace

(a) RESIDENCE NO. Ellicott City St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Wallace

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE Years 64 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) Unknown

(State or country)

14 Informant Richard Wallace

(Address) 1102 Mad. Ave.

15 Filed ..... , 19 .....

Registrar R.W.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Sept 13, 1927, that I last saw her alive on Sept 12, 1927 and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows: Cancer of breast with metastases

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Games M. D.

, 19 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star Cem. Date of Burial Sept 16 19 27

20 UNDERTAKER Samuel A Hensley ADDRESS 1128 Bolton

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 25614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 113 E 25614

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Boblitz

(a) RESIDENCE NO. Eastern Ave & North Pt. Road St. Ward Fair Rend 1

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 13/26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Colgate, Md.

PARENTS

10 NAME OF FATHER Benj. Boblitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Edna Conrad

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Hampton, Va.

14 Informant Mother

(Address)

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Sept 12/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry.)

inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal Indigestion (24- 36 hrs) (Dehydration. Autopsy at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. H. Bullen M. D.

9/15/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sunset Cemetery Date of Burial 9/16 1927

20 UNDERTAKER Louis Heemann ADDRESS 34 S. Bway

Cor.—12-9-25—A Co.—200 Bks.

E 25615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 25615

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1130 N. Pratt St. 18-24 Ward)

2-FULL NAME Harry J. Seals

(a) RESIDENCE NO. 1130 N. Pratt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 24 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 24 / 1927

7 AGE Years: — Months: 2 Days: 22

IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Bal to,

(State or country)

PARENTS

10 NAME OF FATHER: Chas. M. Seals

11 BIRTHPLACE OF FATHER (city or town): Ill -

(State or country)

12 MAIDEN NAME OF MOTHER: Helen K - Bloomer

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Chas M. Seals

(Address) 1130 N. Pratt St

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 192 7

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained Dr Yeiss and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Entero - Colitis

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

Signed Thos B. Horton M. D.

(Coroner)

Sept 15 1927 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial Sept 16 1927

20 UNDERTAKER: John J. Fields ADDRESS 1200 W Lombard

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25616

E 25616

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 220 S. Clinton St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte E. O. Neal.

(a) RESIDENCE NO. 220 S. Clinton St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert O. Neil

6 DATE OF BIRTH (month, day, and year): June 16th 1867

7 AGE — Years: 60 — Months: 2 — Days: 28

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Geo. W. Logan.

11 BIRTHPLACE OF FATHER (City or town): Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Dont Know.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Vermont

14 Informant: Robert O. Neal

(Address): 220 S. Clinton St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Sept 13, 1927

that I last saw h[illegible] alive on Sept 12, 1927

and that death occurred on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Acute Anuria due to Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Indiana

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Findings

(Signed) Thos. Lundy M. D.

9-15 1927 (Address) 208 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

Date of Burial: Sept. 16 1927

20 UNDERTAKER: Lilly & Zeller

ADDRESS: 403 S. Wolfe St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25617

CERTIFICATE OF DEATH.

24-001

E 25617

24-33

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1317 Webster St. Ward)

2-FULL NAME Catherine Thompson.

(a) RESIDENCE NO. 1317 Webster St. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 0 mos. 7 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow.

5a If ~~MARRIED, widowed,~~ ~~XXXXXXXXX~~ (or) WIFE of William Thompson.

6 DATE OF BIRTH (month, day, and year) September 6, 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William O'Toole.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret O'Connor.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant Margaret E. Seibel. (daughter)

(Address) 1317 Webster St.

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 13, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto R. Barkhorn M. D.

(Coroner)

9/14 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial Sept 17 1927

20 UNDERTAKER F. A. Wanderer Son. ADDRESS 703 Hanover St.

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25618
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 25618

CITY OF BALTIMORE: (No. 206 Belmont Ave) (ST.) (WARD) 27-43

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Albert Wilson

(a) RESIDENCE NO. 206 Belmont Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6 DATE OF BIRTH (month, day, and year) Dec 11 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ....min.
	77	9	3.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) 059
(c) Name of employer Wm C Swisher

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS
10 NAME OF FATHER Richard Wilson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Emma Hurst
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Annie B Irwin
(Address) 206 Belmont Ave

15 Filed 9/15 19 27 K. H. Hill Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1927

17
I HEREBY CERTIFY, That I attended deceased from June 22, 1927. to Sept 8, 1927.
that I last saw h[illegible] alive on Sept 8, 1927
and that death occurred, on the date stated above, at 8-30 P m.
The CAUSE OF DEATH* was as follows:
Gastric Carcinoma

CONTRIBUTORY (Secondary) Gastric Carcinoma (duration) 1 yrs. — mos — ds.

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? no Date of ———

Was there an autopsy? no

What test confirmed diagnosis? ———

(Signed) Morris B Green, M. D.
(Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	9. 17. 27
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

Spec.—1-12-23—M&T—500 Bks.

205-879

HEALTH DEPARTMENT—CITY OF BALTIMORE

107-003

E 25619

CERTIFICATE OF DEATH.

E 25619

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Holmes Smith (Smith)

(a) RESIDENCE NO. 2016 Ridgewood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 5-9-86

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 39 | Months 3 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Smith (Smith)

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Jersey

12 MAIDEN NAME OF MOTHER: Elizabeth Smith (Smith)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Jersey

14 Informant: Records (Address): JOHNS HOPKINS HOSPITAL

15 Filed , 19 R.M.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1927

17

I HEREBY CERTIFY, That I attended deceased from July 14, 1927, to Sept-15, 1927, that I last saw h alive on Sept-15, 1927, and that death occurred, on the date stated above, at 4:50 A.m.

The CAUSE OF DEATH* was as follows:

lung abscess

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 8-23-27

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) George G. Finney, M. D.

9/15/27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 17 1927

20 UNDERTAKER: H. Cook — ADDRESS: 502 Mulberry

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25620

CERTIFICATE OF DEATH.

74-001

E 25620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N. Caroline ST. 5-9 WARD)

2-FULL NAME Rosina F. Wagner

(a) RESIDENCE NO. 414 N. Caroline ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Divorced

5a If married, widowed, or divorced (Husband of) (or) WIFE of Chas Wagner

6 DATE OF BIRTH (month, day, and year) March 25-1856

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
71	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Kaiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosina Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Elizabeth Preis

(Address) 414 N Caroline

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1927, to Sept 14, 1927,

that I last saw her alive on Sept 14, 1927

and that death occurred, on the date stated above, at 9.35 P m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R C Davis, M. D.

, 19 (Address) 1509 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 16 1927

20 UNDERTAKER Mrs Cook

ADDRESS 502 Elwood Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25621

CERTIFICATE OF DEATH.

12 E 25621

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Charitable Home ST., 6-10 (WARD)

2-FULL NAME Nathan Solonsky

(a) RESIDENCE NO. 2100 E Balt St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ...
(State or country) Russia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lurie
(Address) 1439 Eastern Ave

15 Filed ....., 19 Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/27 19

17

I HEREBY CERTIFY, That I attended deceased from May, 1927, to Sept 16, 1927,

that I last saw h[illegible] alive on Sept 16, 1927,

and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

ch. nephritis

(duration) 7 yrs. ... mos ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1510 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Wilson Cem	19
20 UNDERTAKER Levitt Pointe Co	ADDRESS Jack Lurie 1439 Eastern

Spec.—1-12-23—M&T—500 Blks.

E 25622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 E 25622

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3940 Park Heights Av ST. 15-56 WARD)

2-FULL NAME Sally S. Ball

(a) RESIDENCE No. 3940 Park Heights av ST. ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Ball

6 DATE OF BIRTH (month, day, and year) July 5. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	87	2	10.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER David S. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Lyford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Virgie Ayres (Address) 13 Carpenter place

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1927

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to Sept 15, 1927, that I last saw h[illegible] alive on Sept 15, 1927 and that death occurred, on the date stated above, at 5:18 m

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestine

(duration) yrs. 3. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James B Ackerman M. D.

19 [illegible] Address 3912 Park Heights av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mt Cemetery DATE OF BURIAL Sept 17 1927

20 UNDERTAKER James B Ayres ADDRESS 1324 Eutaw pl

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25623 ✓ 90 E 25623

REGISTERED NO.

1-PLACE OF DEATH Aged Womens Home

City of BALTIMORE: (No. 1400 W Lexington St., 1927 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Kirby

(a) RESIDENCE NO. 1400 W Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 15, 1840

7 AGE: Years 86 Months 9 Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Zamell R Kirby

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Eleanor Hunter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Annapolis Md

14 Informant (Address) Ella L Ford 1400 W Lexington

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1927 to Sept 15, 1927

that I last saw h alive on Sept 15, 1927

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows: Senility

..... (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin B Dorsett M. D.

, 19 (Address) 1115 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial: Sept 17 1927

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins

Very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25624

CERTIFICATE OF DEATH

129

E 25624

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1100 N.Milton Ave St., 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ANNA STRECZYNSKA,

(a) RESIDENCE NO. 1100 N.Milton Ave St. 8 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female,	White,	Widow,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Martin Streczynski,

6 DATE OF BIRTH (month, day, and year) August 25- 1852.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER ******* Nowak,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Mrs. Vincent Conrad, (Daughter

(Address) 1100 N.Milton Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 September 15

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to Sept 15, 1927, that I last saw h alive on Sept 15, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

9/15. 1927 (Signed) Frank Jannuzzo M. D.

(Address) 243 East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemtery. Date of Burial Sep. 19. 1927

20 UNDERTAKER M. F. Sadowski. ADDRESS 705 S Ann St

of certificates.

...ion to back of this certificate. For instructions see back of this certificate.

Spec.—1-12-23—M&T—500 Bks.

310 W Lanvale St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25625

CERTIFICATE OF DEATH.

122-002

REGISTERED NO. E 25625

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 310 W Lanvale St., 11-74 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Nicodemus

(a) RESIDENCE No. 310 W Lanvale St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nannie Nicodemus

6 DATE OF BIRTH (month, day, and year): Dec 23, 1856

7 AGE: Years 70 Months 8 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Agt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jeremiah Nicodemus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Harriet Earhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Anna Nicodemus

(Address) 310 W Lanvale St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3rd, 1927, to Sept 15th, 1927, that I last saw him alive on Sept. 15th, 1927, and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver and Albuminuria

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Charles Hurst, M. D.

, 19 (Address) 310 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Sept 17 19 27

20 UNDERTAKER: J. H. Cook — ADDRESS: 501 E Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25626

CERTIFICATE OF DEATH.

100-001

E 25626

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2740 St. Paul St. 12-50 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Irene Funk Smith

(a) RESIDENCE. No. 2740 St. Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Willard M. Smith

6 DATE OF BIRTH (month, day, and year): Jan. 13, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Funkstown, Md.

PARENTS

10 NAME OF FATHER: Ephraim Funk

11 BIRTHPLACE OF FATHER (city) (State or country): Washington Co., Md.

12 MAIDEN NAME OF MOTHER: Rebecca F. Knode

13 BIRTHPLACE OF MOTHER (city or [illegible]) (State or country): Frederick, Md.

14 Informant: Mamie L. Funk
(Address): 2720 St. Paul St.

15 Filed ..., 19 ... Registrar

SEP 16 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1927, to Sept. 15, 1927, that I last saw her alive on Sept. 15, 1927, and that death occurred, on the date stated above, at 8.15 a.m.

The CAUSE OF DEATH* was as follows:

Acute Delirium
(Bell's Mania)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Acute Broncho-Pneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Wm. M. Pannebaker, M. D.

9/15 1927 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Sept 17 1927

20 UNDERTAKER: Wm J Jackson, Jones

ADDRESS: Ho Falls

Spec– 12-23-21—E.B.R.S.—400 Eks.

E 25627

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25627

CERTIFICATE OF DEATH.

Registered No. 15960

1-PLACE OF DEATH 2223 Raslyn ave Walbrook Md

City of BALTIMORE: (No. 2223 Raslyn ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Rothert

(a) Residence No. 2223 Raslyn ave St., ... Ward ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word) Widow

5a-If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of J. Herman Rothert

6-DATE OF BIRTH (month, day and year) Sept. 12, 1851

7-AGE. 76 yrs. 0 mos. 2 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer ...

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Jefferson Baugerman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Eliza J. Helen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) Elmer Hoffman
(Address) 2223 Raslyn ave

15- Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 14, 1927

17- I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1927, to Sept. 14, 1927, that I last saw her alive on Sept 14, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ... yrs. 0 mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual clinical tests

(Signed) A. A. Macdonald, M. D.

Sept 16, 1927 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem — DATE OF BURIAL. Sept 17, 19..

20-UNDERTAKER. Wm J Treherne Sons — ADDRESS Eutaw

Spec.—1-10-21—M&T—1500 Bks.

E 25628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25628

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1729 W. Lanvale Street

CITY OF BALTIMORE: (NO. 1729 ST. 16-22 WARD)

2-FULL NAME Mary Jane Botts

(a) RESIDENCE NO. 1729 W. Lanvale ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James A. Botts

6 DATE OF BIRTH (month, day, and year): Unknown 1860

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Annie Withers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: James A. Botts

(Address) 1729 W. Lanvale St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-15 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-5, 1927, to 9-15, 1927, that I last saw he alive on 9-15, 1927, and that death occurred, on the date stated above, at 4.52 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

19 (Address) 725 N. Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Boulton Va — DATE OF BURIAL: Sept 17 1927

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 1725 Ashland Ave

1027C HARRISON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 25629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 25629

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 Ridge ave ST. 27-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel J. Dolan

(a) RESIDENCE No. 619 Ridge ave, ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE — Years: 61 — Months — Days — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chief Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): U.S. Navy 031

(c) Name of employer: U.S. Government

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: John Dolan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margt. Loughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ire.

14 Informant: Mary Schneider (Address) 619 Ridge ave.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14 1927

17 I HEREBY CERTIFY, That I attended deceased from May 3rd, 1927, to Sept 14, 1927, that I last saw h— alive on Sept 13, 1927, and that death occurred, on the date stated above, at 3-15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Arteriosclerosis 1 yr 8 mos.

Where was disease contracted if not at place of death? Marine Engineer

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Edw. H. Benson, M. D.

(Address) Orleans Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: 9/17/1927

20 UNDERTAKER: A. Moran — ADDRESS: 300 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

E 25630

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25630

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1803 E. Jefferson ST. 6-9 (WARD)

2-FULL NAME Karen Olsen

(a) RESIDENCE NO. 1803 E. Jefferson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andreas Olsen

6 DATE OF BIRTH (month, day, and year) Aug 16 53

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	~~5~~	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER — Larsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER — Johansen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant (Address) Anthony Olsen 1803 E. Jefferson

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14/27

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 19 27, to Sept 14, 19 27, that I last saw h alive on Sept 13, 19 27, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Senility

Final unconsciousness

Heart failure

(duration) ~ yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Parkview DATE OF BURIAL 9/17 1927

20 UNDERTAKER J. C. Moran ADDRESS 3000 E. Balto St.

Spec.—1-12-23—M&T—500 Bks.

E 20 25631

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25631

CERTIFICATE OF DEATH.

× 135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer McPherson

(a) RESIDENCE NO. 700 Beechhurst Av. Roslyn W. Va ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced, (write the word)~~
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Margaret

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George McPherson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER M. Kitty Mill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Richard JOHNS HOPKINS HOSPITAL (Address)

15 Filed . 19 NRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1927

17 I HEREBY CERTIFY, That I attended deceased from August 30, 1927, to Sept 16, 1927, that I last saw h[illegible] alive on Sept. 16, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia. Nephritis (Chronic Glomerulo)

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 3, 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris Myers, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Boonsboro Md	Sept 16 27
20 UNDERTAKER	ADDRESS
Stewart Mowen Co	1080 W. North ave

Cor.—12-9-25—A Co.—200 Bks.

E 25632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169 E 25632

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Lake W.H. Park. St. 2755 Ward

2-FULL NAME Geo E Fuchs

(a) RESIDENCE NO. 2217 N Belvidere St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elfrieda Funk

6 DATE OF BIRTH (month, day, and year): Jan 18 1873

7 AGE — Years: 54 — Months: 7 — Days: 27 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer): Grocery Business

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: William Funk

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant (Address): Elfrieda Funk 2217 N. Belvidere Ave

15 Filed..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Drowning
Asphyxia
Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)
Duration yrs. mos. ds.

Sealed) M. D.
(Coroner)
(Address) 1431 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Sept 17 1927

20 UNDERTAKER: H. & H. Smith — ADDRESS: 501 W. Fayette

Spec.—1-10-21—M&T—1500 Blks.

E 25633

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 25633

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2943 W. Lanvale St., 16-67 WARD)

2-FULL NAME Pauline Connelly.

(a) RESIDENCE NO. 2943 W. Lanvale St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Connelly.

6 DATE OF BIRTH (month, day, and year) Nov. 20. 1867.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	9	25 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Helen K. Connelly. (Address) 2943 W. Lanvale St.

15 Filed . 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 5. 19 27. to Sept 13. 19 27.

that I last saw her alive on Sept 14. 19 27.

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Haemorrhage

CONTRIBUTORY (Secondary) General Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John G. Schwenstorg M.D.

. 19 (Address) 11 New Church St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL Sept 19 1927

20 UNDERTAKER Mr & Mrs J. W. Penfold & Son — ADDRESS 808 W. Fayette

Cor.—12-9-25—A Co.—200 Bks.

E 25634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1888 E 25634

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mur Hospital 214 St. Ward)

2-FULL NAME Harry Gygner.

(a) RESIDENCE NO. 604 Scott St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 16 1899

7 AGE: Years 28 Months 5 Days 30 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto - Md

PARENTS

10 NAME OF FATHER John G Gegner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louisa Leffler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant: John G Gegner

(Address) 604 Scott

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to Leo death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc.

Multiple Fracture

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

Signed Jos C Blades M. D.

(Coroner)

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Sept 19 1927

20 UNDERTAKER: Mrs Mrs. J. W. Teufel & Son ADDRESS 501 N Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~E~~ 25635 ✓ 17E 25635

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 Myrtle Ave ST., 4-W WARD)

2-FULL NAME Blanche Wilson

(a) RESIDENCE NO. 237 Myrtle Ave ST., 4-W WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Col

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Wilson

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE Years 41 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Mr. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Eva Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Mrs Wilson 237 Myrtle ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1927

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1927, to Sept 15, 1927, that I last saw ~~h~~ alive on Sept 14, 1927, and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ... yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno. C. Wilson M. D.

19 (Address) 1716 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Sept 17 1927

20 UNDERTAKER Lemmert Eastern ADDRESS 916

Spec.—1-10-21—M&T—1500 Bks.

E 25636

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 Small ST. 10-14 WARD) 44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E. Gruen

(a) RESIDENCE NO. 1314 Small ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie Gruen

6 DATE OF BIRTH (month, day, and year): 1896

7 AGE: Years 31 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Elsie Gruen

(Address): 1314 Small st.

15 Filed . 19 Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 . 1927 . to Sept 14 . 1927 .

that I last saw him alive on Sept 14 . 1927

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Sarcoma

. . (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

. . (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Manley Hoag M. D.

Sept 15, 1927 (Address) 729 Eutaw St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Burn

DATE OF BURIAL: Sept 17, 1927

20 UNDERTAKER: David Carter

ADDRESS 416 Eutaw

Spec.—12-9-25—A Co.—200 Bks.

E 25637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25637

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) German Aged Home Ward 20-27

2-FULL NAME Katherine M. Carrell

(a) RESIDENCE NO. German Aged Home Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 18 1846

7 AGE: Years 81 | Months 4 | Days 29 | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): G

(State or country) Germany

PARENTS

10 NAME OF FATHER Johann Roeser

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany?

12 MAIDEN NAME OF MOTHER Margaretha ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant (Address) German Home Records Balto. Co. Payson St.

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1927 to Sept. 15th 1927, that I last saw h.. alive on Sept 15th 1927, and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Hewitt, M. D.

9/16, 1927 (Address) 1843 W. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. Date of Burial: Sept 17 1927

20 UNDERTAKER: Joseph B. Cook ADDRESS: 1003 N. Balto St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 25638

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25638

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1801 St Paul St. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Washington Wheeler

(a) Residence No. 180/ St Paul St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ann E. Blocker

6-DATE OF BIRTH (month, day and year) 12/29/1850

7-AGE. 76 yrs. 8 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer Sol + Co

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS

10-NAME OF FATHER. John Wesley Wheeler

11-BIRTHPLACE OF FATHER (city or town) (State or Country) A.A. Co. Md.

12-MAIDEN NAME OF MOTHER. Caroline Wharton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Mrs Rose Wright

(Address) 180/ St. Paul St.

15-

Filed ..... 192.....

Registrar.

DEC 1927 C. HUNSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 11-1927

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1927 to Dec 11 1927

that I last saw h.... alive on Dec 11 1927

and that death occurred, on the date stated above, at 8:25 a m.

The CAUSE OF DEATH* was as follows:

Chronic hypertrophic and Chronic Parenchymatous Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis

Lobar Pneumonia (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert L. Hudelson M. D

Dec 11 1927 (Address) 711 W Mount Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem.

DATE OF BURIAL. 12/13/1927

20-UNDERTAKER. Mary M. Wiedefeld

ADDRESS 501 E 22nd St

Spec—12-23-21—E.B.R.S.—400 Bks.

25639

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 803 E. 22 St. 9-46 St., Ward)

Registered No. [redacted]

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Goldrick

(a) Residence No. 803 E. 22 St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, Divorced (write the word): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Goldrick

6-DATE OF BIRTH (month, day and year): June 30 1849

7-AGE: 78 yrs. 2 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Edward Boyle

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Marg. Hawkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant) Mrs Mamie Rinn

(Address) 803 E. 22 St.

15-

Filed 19

Registrar.

RPK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 14 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct. 10 1926 to Sept. 14 1927

that I last saw him alive on Sept. 14 1927

and that death occurred, on the date stated above, at 6.15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Palatic Fund.

(Duration) yrs 11 mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) William J. Tillsbury M. D

19 (Address) 415 Cedarcroft Road

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Marys Govans	9/17 19 27
20-UNDERTAKER.	ADDRESS
Mary M. Wiedefeld	501 E 22 St.

Spec.–7-17-26—A Co.—200 Bks.

E 25640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25640

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Fiedler

(a) RESIDENCE NO. 129 N. Rose St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 45 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Fiedler

6 DATE OF BIRTH (month, day, and year): June 13 1864

7 AGE: Years 63 Months 3 Days 3

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Box Breaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: John Fiedler

11 BIRTHPLACE OF FATHER (City or town): Germ.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Fiedler

13 BIRTHPLACE OF MOTHER (city or town): Germ.

(State or country)

14 Informant: Mrs. Frances Fiedler

(Address) 129 N. Rose St.

15 Filed , 19

1927 Per A R H Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/16/27 19

17

I HEREBY CERTIFY, That I attended deceased from 8/25/27, 19 , to 9/16/27, 19 .

that I last saw h/ alive on 9/16/27, 19 .

and that death occurred, on the date stated above, at 9 15 A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/9/27

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. L. Whitehurst M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial Sept 19 19 27

20 UNDERTAKER: Jos. J. Herr ADDRESS 156 N. Eutaw

Keep important. Not directions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25641

CERTIFICATE OF DEATH.

113 E 25641

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2 Mc Tavish St. 70-70 Ward)

2-FULL NAME Albert Kenneth Holly

(a) RESIDENCE NO. 2 Mc Tavish St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 18 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Holly

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Irene Tyree

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Irene Holly

(Address) 2 Mc Tavish St

15 Filed _____, 19____ _____ Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 9, 1927, to Sept 16, 1927, that I last saw him alive on Sept 16, 1927, and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Leuco Colitis

(duration) ___ yrs. ___ mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Wilbeam Irey, M. D.

9/17, 1927 (Address) 1928 La Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Western Star Cemetery	Sept 17, 1927
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	322 N. Schroeder St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25642

CERTIFICATE OF DEATH.

154-002

E 25642

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1331 N. Eden St., 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Burton

(a) RESIDENCE NO. 1331 N. Eden St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16/27

7 AGE	Years	Months	Days	IF LESS than 1 day...hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James E. Burton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Annabel Hamann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant James E. Burton

(Address) 1331 N. Eden St

15 Filed....., 19..... C. Lamson Jones, M. D. Registrar

1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Congenital Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Joseph Falls M. D.
(Coroner)

9/18/27 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial 9 | 17 | 1927

20 UNDERTAKER George J. Ruth

ADDRESS 1738 Hanford Ave

Spec.—1-10-21—M&T—1500 Bks.

E 25643 HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 25643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3261 N. Robinson St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah J. Graff

(a) RESIDENCE No. 3261 N. Robinson ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced, (of) WIFE of Henry F. Graff

6 DATE OF BIRTH (month, day, and year) June 27 1875

7 AGE Years 52 Months 2 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10 NAME OF FATHER Silas T. Austin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

12 MAIDEN NAME OF MOTHER Mary Stortz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Mrs. Graff (Address) 3261 N. Robinson St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Sept 14, 1927.

that I last saw her alive on Sept 13, 1927

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Test & pathalogical tests at Johns Hopkins Hospital

(Signed) J. M. Dilgard, M. D.

(Address) 624 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int. Carmel Cem. DATE OF BURIAL 9/17/27

20 UNDERTAKER J. A. Moran ADDRESS 3000 E. Baltimore

Spec.–7-17-26—A Co.—200 Bks.

BAKER

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25644 ✓ 14-006 E 25644

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Baker

(a) RESIDENCE NO. 2617 Bernard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. (b)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. Carolina

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1927, to Sept 16, 1927, that I last saw him alive on Sept. 16, 1927, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - right. Cerebral hemorrhage - left. Hypertension Arteriosclerosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Appearance

(Signed) C. Holmes Bourne, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hospital Date of Burial Sept 17 1927

20 UNDERTAKER Chenault & Son ADDRESS 3675 Belair Rd

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25645

CERTIFICATE OF DEATH

129 E 25645

1-PLACE OF DEATH

City of BALTIMORE: (No. Esplanade Apts St. 13-59 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henriette Kaufman

(a) RESIDENCE NO. Esplanade Apt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rafel Kaufman

6 DATE OF BIRTH (month, day, and year): Dec. 6th 1837

7 AGE — Years: 89 — Months: 9 — Days: 10 — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Isaac Greenbaum

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mitchell

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germy

14 Informant: Mattie Greenbaum

(Address): Fidelity Bldg

15 Filed ..., 19 ... Registrar

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16 1927

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1926 to Sept. 16, 1927.

that I last saw h[er] alive on Sept. 15, 1927.

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Pulmonary Edema, Ch. Nephritis

(duration) several years

CONTRIBUTORY (Secondary) Old age, arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Theodore H. Thomson M. D.

. 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew — Date of Burial: 9/18 1927

20 UNDERTAKER: David Sondheim — ADDRESS: 118 W. Mt. Royal Ave

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 25646

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25646

CERTIFICATE OF DEATH

86-001

REGISTERED NO. .....

1-PLACE OF DEATH Md. General Hospital

City of BALTIMORE: (No. ..... St 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rakowska

(a) RESIDENCE NO. 2022 Fleet St.

(Usual place of abode) Ward .....

Length of residence in city or town where death occurred 1 yrs. 7 mos. 8 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) May. 8. 1926

7 AGE

Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
1	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) 2024 Fleet St

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Chesta Rakowska

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Lamoski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Hospital records (Address) .....

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927 to Sept 16, 1927

that I last saw h alive on Sept 16, 1927

and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Colitis Amebic - Bilateral

Ileo-Colitis

E.

..... (duration) ..... yrs. ..... mos. ? ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (duration) ..... yrs. ..... mos. 15 Min

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 16, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Rosary Cem Sept 17 1927

20 UNDERTAKER — ADDRESS

John M Weber 1803 Bank St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25647

CERTIFICATE OF DEATH

E 25647

1-PLACE OF DEATH Baltimore City Hospt

REGISTERED NO. 38

City of BALTIMORE: (No. Balto. Md St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Phillips

(a) RESIDENCE NO 1716 Druid Hill Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Julia Phillips

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ost

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant (Address) Balto City Hospt Balto Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

9-15-27

17 I HEREBY CERTIFY, That I attended deceased from 7-21- ..., 1927, to 9-15 ..., 1927, that I last saw him alive on 9-15 ..., 1927, and that death occurred, on the date stated above, at 8.50 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonic Infection

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Serological

(Signed) Harry Bridges Lowe M. D.

9/16/27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYL Date of Burial SEP 19 1927 19

20 UNDERTAKER: Commissioner Health ADDRESS

1716 Druid Hill Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25648

CERTIFICATE OF DEATH.

1880-002

E 25648

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hosp St 21 29 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosina Shilow

(a) RESIDENCE NO. 1012 N Broad St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ignatius Shilow

6 DATE OF BIRTH (month, day, and year): Jan 2 1864

7 AGE: Years 65 Months 8 Days 2 If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 27

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm C Gaver

11 BIRTHPLACE OF FATHER (city or town)

(State or country): U S A

12 MAIDEN NAME OF MOTHER: Mary A Stanger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto Md

14 Informant: Emma E Shilow

(Address): 1012 N Broad St

15 Filed ..... 19 .....

NKB Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 15 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc

Multiple Fractures

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Sept 15 27 (Signed) H Lock M. D.

(Coroner)

(Address) 143 W Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Date of Burial Sept 19 192 7

20 UNDERTAKER: J H Cook ADDRESS 512 Park Ave

Spec.—1-10-21—M&T—1500 Bks.

E 25649

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 97-69 WARD)

REGISTERED NO. 1177

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Garner

(a) RESIDENCE NO. 456 S. Fremont ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace E Garner

6 DATE OF BIRTH (month, day, and year) Dec 18 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Furnisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Montgomery Ward

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER Conrad Garner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C

12 MAIDEN NAME OF MOTHER Rebecca Hammock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D C

14 Informant Mrs Grace Garner

(Address) 456 S. Fremont Ave

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M.D.

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-10, 1927, to 9-16, 1927, that I last saw him alive on 9-16, 1927, and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Perforative Appendicitis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-10-27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Louis M Tolliver, M. D.

, 19 (Address) Franklin Square Hospital Calhoun & Fayette Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept 19 1927

20 UNDERTAKER H H Cook — ADDRESS 507 E Baltimore

Cor.—12-9-25—A Co.—200 Bks.

E 25650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-03

E 25650

1-PLACE OF DEATH

City of BALTIMORE: (No. Mir Hospital St. 21-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur R Davis

(a) RESIDENCE NO. 833 N. Broos St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23 1886

7 AGE — Years: 41 Months: 2 Days: 16

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dr & Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 245

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER William B Davis

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary C McCall

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country) Md

14 Informant: William B Davis

(Address) 833 N Broos St

15 Filed 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest and Inquiry find that said deceased came to death

(Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc

Multiple Fractures

Shock

CONTRIBUTORY (Duration) yrs. mos. ds.

(Secondary)

(Duration) yrs. mos. ds.

Signed Geo Blades M. D.

(Coroner)

1927 (Address) 143 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Date of Burial Sept 19 1927

20 UNDERTAKER Mc Cook ADDRESS 502 E North Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25651

CERTIFICATE OF DEATH.

3 E 25651

1-PLACE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 916 Edmondson Ave. Ward)

2-FULL NAME Jane Bolling

(a) RESIDENCE NO. 916 Edmondson Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Bolling

6 DATE OF BIRTH (month, day, and year): April 9, 1863

7 AGE: Years 64 Months 5 Days 10 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): painter

(c) Name of employer

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER: Wm. Bolling

11 BIRTHPLACE OF FATHER (city or town): Va.

(State or country)

12 MAIDEN NAME OF MOTHER: Eliz. Martin

13 BIRTHPLACE OF MOTHER (city or town): Va.

(State or country)

14 Informant: Mrs. Bessie Kelly

(Address) 916 Edmondson Ave

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 14, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Thr.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Hennessy, M. D.

(Coroner)

19 x 7 (Address) 2 57 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greensboro, N. C. Date of Burial: Sept 17 19 27

20 UNDERTAKER: J. M. Koch ADDRESS 532 E Lafayette

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25652

CERTIFICATE OF DEATH

1384 E 25652

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital 5-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Diggs Harrington

(a) RESIDENCE NO. 514 N Rutter Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Percy Harrington

6 DATE OF BIRTH (month, day, and year): 1900

7 AGE: Years 29 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) NC

(State or country)

PARENTS

10 NAME OF FATHER Alex. Diggs

11 BIRTHPLACE OF FATHER (City or town)

(State or country) NC

12 MAIDEN NAME OF MOTHER Eden Diggs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) NC

14 Informant Percy Harrington

(Address) 514 N Rutter Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 19 29

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 19 29 to Sept 15, 19 29

that I last saw her alive on Sept 15, 19 29

and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) ..... yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis — Abscess

(duration) ..... yrs. mos 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8-30-29

Was there an autopsy? no

What test confirmed diagnosis? Physical - Operation

(Signed) [illegible] M. D.

Sept 15, 19 29 (Address) 508 Summit ST

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — Date of Burial: Sept 17 1929

20 UNDERTAKER: Jos. T. H. Rochester — ADDRESS: 1413 Jefferson St

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25653

CERTIFICATE OF DEATH

E 25653

1-PLACE OF DEATH 3401 Fairview ave

City of BALTIMORE: (No. 3401 Fairview ave St. 15-61 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma McClanahan

(a) RESIDENCE NO. 3401 Fairview ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 ~~Single, Married~~, Widowed, ~~Divorced~~, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8-1850

7 AGE Years 77 Months 8 Days 7

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Preston P. Johnston

11 BIRTHPLACE OF FATHER (City or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth McClanahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant J. M. Kemp

(Address) 3401 Fairview ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15—1927 6.30 PM

17 I HEREBY CERTIFY, That I attended deceased from ~~Feb~~ Feb. 1, 1927, to Sept 15/1927, 19....

that I last saw ~~her~~ alive on Sept 14/1927 19....

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

arterio sclerosis & high blood pressure - chronic interstitial nephritis - cerebral hemorrhage & paralysis

Myocarditis (duration) about 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) as stated above - myocarditis

(duration) about 10 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W S Nisbet Jr M. D.

9/17/27 19 (Address) 5520 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial Sept 19 1927

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 25654 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25654

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Brentwood ave ST., 10-15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles D. Alderson

(a) RESIDENCE NO. 1009 Brentwood ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Maryland V Alderson

6 DATE OF BIRTH (month, day, and year) Dec 13th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator Operater

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md.

PARENTS

10 NAME OF FATHER Thomas Alderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Mary J Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Ella Alderson

(Address) 1009 Brentwood ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 1927 to Sept 15 1927.

that I last saw h[illegible] alive on Sept 15 1927,

and that death occurred, on the date stated above, at 6 00 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W G Jones M. D.

9/16 1927 (Address) 730 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N't Olivet Cemetery	Sept 14th 1927
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

Spec.–1-10-21–M&T–1500 Bks.

E 25655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25655

1-PLACE OF DEATH

Howard A. Kelly Hosp Pvt

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST., 14-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. J. P. Kuntz (Eva D.)

(a) RESIDENCE NO. Lorraine Ohio ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Philip Kuntz

6 DATE OF BIRTH (month, day, and year): Jan 30 1877

7 AGE: Years 50 Months 7 Days 18 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Baltimore Ohio

PARENTS

10 NAME OF FATHER: Benjamin F. Dreitzler

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Lima Ohio

12 MAIDEN NAME OF MOTHER: Martha Schaaf

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John P. Kuntz (Address) 1127 Broadway Lorraine Ohio

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1927, to Sept 17, 1927.

That I last saw him alive on Sept 17, 1927,

and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Sarcoma Scalp.

Lost Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Metastasis to Lungs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of June 3 1927

Was there an autopsy? No.

What test confirmed diagnosis? Pathological & X Ray.

(Signed) Duncan Kuhn Jr., M. D.

Sept 17, 1927 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Ohio — DATE OF BURIAL: Sept 17 1927

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North Ave

Spec.—1-12-23—M&T—500 Blks.

E 25656

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25656

160

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 S Washington ST. 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Kirepka

(a) RESIDENCE No. 606 S Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Kirepka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Labedzenka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Adam Kirepka

(Address) 626 S Washington ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 19 27 to Sept 16, 19 27

that I last saw him alive on Sept 16, 19 27

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cranitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Dr Samuel Silverstein M. D.

(Address) 222 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. Cem.

DATE OF BURIAL 9-17 1927

20 UNDERTAKER John F Weber.

ADDRESS 1803 Bank St.

Spec.—1-12-23—M&T—500 Bks.

E 25657 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

V
10-002
E 25657

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 15-68 WARD)

2-FULL NAME Frances May Backer

(a) RESIDENCE NO. 1633 Warwick Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Non Resident yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	3	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Chas. H. Backer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Gussie Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Chas. H. Backer
(Address) 1633 Warwick Ave

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1927, to Sept 16, 1927, that I last saw her alive on Sept 16, 1927, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Nasal + Tonsillar Diphtheria

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical appearance

(Signed) Myron G. Tull, M. D.

9/17 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	9/18 1927

20 UNDERTAKER ADDRESS 9/17/27

Jos Lippman & Bro 1 Balto St

Spec.—1-12-23—M&T—500 Blks.

E 25658 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25658

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 E. Baltimore ST. 5-8 WARD)

2-FULL NAME David Swinkler

(a) RESIDENCE NO. 730 E. Baltimore ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jake Swinkler

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE — Years: 62 — Months: — Days: — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Mutard Swinkle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Ida Ephraim

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Mrs. Sturwitz 730 E. Baltimore St.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 12 1927

17 I HEREBY CERTIFY, That I attended deceased from September 12, 1927, to September 16, 1927, that I last saw him alive on September 16th, 1927, and that death occurred, on the date stated above, at 10:25 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

Chronic myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hour - H.

(Signed) Boris S. Schwinkler, M. D.

, 19 (Address) 1511 Eastern Ave City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nelson Friendship

DATE OF BURIAL: 9/16 19 27

20 UNDERTAKER: Jack Levis

ADDRESS: 1439 Druid St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25659

CERTIFICATE OF DEATH.

188-003

E 25659
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hosp. Ward 56

2-FULL NAME Meyer E. Schoenfeld

(a) RESIDENCE NO. 1008 E. Baltimore Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred 7 yrs. 6 mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Male

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26 1920

7 AGE — Years: 7 — Months: 6 — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Leon Schoenfeld

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Mary Cohen

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Russia

14 Informant (Address): Leon Schoenfeld 1008 E Baltimore

15 Filed....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Fract. Skull

Accidentally struck by auto while

5 Hrs. (duration) Immediate yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Signed) (Coroner) M. D.

, 19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon — Date of Burial 7/18 192 7

20 UNDERTAKER: Jack Levin — ADDRESS 1439 E Balto

Spec.—1-12-23—M&T—500 Bks.

Amon H Shipley

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25660

CERTIFICATE OF DEATH

129 E 25660

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Hospital ST., 13-51 (A WARD)

2-FULL NAME Amon H Shipley

(a) RESIDENCE NO. 3529 Sweet air ST.; WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Amon Shipley

6 DATE OF BIRTH (month, day, and year) Mar 3-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	72	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Carrol County Md

PARENTS

10 NAME OF FATHER — Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Cnty Md

12 MAIDEN NAME OF MOTHER Sarah Ebaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Rosa Shipley (Address) 3529 Sweet air St

15 Filed . . 19 . . Registrar RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 29 , 1927 , to Sept 16 , 1927 , that I last saw him alive on Sept 16 , 1927 and that death occurred, on the date stated above, at 11 P m

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uremia

(duration) one yrs — mos — ds

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs — mos. one ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 9/11/27

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) S. C. Feldman M. D.

. 19 (Address) 1101 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Cemetery DATE OF BURIAL Sept 19 1927

20 UNDERTAKER A S Marshall 3539 Fallsrd

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25661

CERTIFICATE OF DEATH

31 E 25661

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3318 Hudson St. 26 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Mack.

(a) RESIDENCE NO. 3318 Hudson St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Mack.

6 DATE OF BIRTH (month, day, and year) Aug 23rd 1886

7 AGE	Years	Months	Days
	41	1	23

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Longshoreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (City or town)

(State or country) " "

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) " "

14 Informant Anna Mack

(Address) 3918 Hudson St

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Sept 16, 1927, that I last saw him alive on Sept 15, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

* Tuberculosis of Lungs

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos da.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation + Tests

(Signed) Thomas B Tilton, M. D.

9/17, 1927 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Oak Hill Cemetery	Sept 20 1927
20 UNDERTAKER Lilly + Zeiler	ADDRESS 403 S Wolfe

Very Important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25662

CERTIFICATE OF DEATH

31 E 25662

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 7 N. Highland Ave St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Michael Heinle

(a) RESIDENCE NO. 7 N. Highland Ave St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7th mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude Heinle

6 DATE OF BIRTH (month, day, and year): June 23rd 1870

7 AGE — Years: 57 Months: 2 Days: 23 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Michael Heinle.

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Elizabeth Deckse

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto. Md.

14 Informant: Gertrude Heinle Wife

(Address): 7 N. Highland ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 15th 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 19 27 to Sept. 15 19 27

that I last saw him alive on Sept. 15 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Pulmonary Hemorrhage,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Renal Cortical Calculus

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos. H. Faulkner M. D.

(Address) 3508 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Sept 19th 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25663

74-001 E 25663

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1839 E. Eager St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily J. Ellison

(a) RESIDENCE NO. 839 E. Eager St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estate Geo. J. Ellison

6 DATE OF BIRTH (month, day, and year) April 21st 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	77	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co Md

(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Nellie Sommerville

(Address) 3462 Seneca St.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 19 27 to Sept 17 19 27

that I last saw h[illegible] alive on Sept 17 19 27

and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos 20 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallace I. Rowan M. D.

(Address) 801 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Schwartz Cemetery	Sept. 20th 1927
20 UNDERTAKER Lilly & Gilet	ADDRESS 1038 W Fayette St

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25664

CERTIFICATE OF DEATH.

11-001

E 25664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4164 Register ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Davis

(a) RESIDENCE NO. 416 N Regester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fannie Lyles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Geo Davis Father

(Address) 416 N Regester

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-17 19 27

17 I HEREBY CERTIFY, That I attended deceased from 9-16 , 19 27 , to 9-17 , 19 27 .

that I last saw h alive on 9-16 , 19 27 ,

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Lindenmuth, M. D.

9-17, 19 27 (Address) 2011 E. 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Antioch Cemetery

DATE OF BURIAL Sept 18 19 27

20 UNDERTAKER Robert E Williams

ADDRESS 1515 Mt Elderry Rd

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E-25665 DEATH

REGISTERED No. E 25665

CITY OF BALTIMORE: (No. 3521 Benson St. WARD) 43-57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willard Hoover Jr.

(a) RESIDENCE No. 3521 Benson St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER Willard Hoover

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Ester Butler

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Willard Hoover
(Address) 3521 Benson St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17, 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 14, 1927, to Sept 17, 1927

that I last saw him alive on Sept 17, 1927

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Icterus neonatorum

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.

9/17, 1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hampden	Sept 19, 1927.
20 UNDERTAKER	ADDRESS
Thenowetson	3615 Gaston Ave

Cor.—12-9-25—A Co.—200 Bks.

Wisniewski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25666

CERTIFICATE OF DEATH.

E 25666

1-PLACE OF DEATH

City of BALTIMORE: (No. 258 S Dallas St., 3-1 Ward)

2-FULL NAME William Disniewski

(a) RESIDENCE NO. 258 S Dallas St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) February 15, 1927

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	—	7	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Stanley Disniewski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Michigan

12 MAIDEN NAME OF MOTHER Johanna Rayboke

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Germany

14 Informant Stanley Wisniewski

(Address) 258 S Dallas.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1927

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death at the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Contributory (Secondary) Laughon

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G Hader M. D.

(Corner)

Sept 18, 1927 (Address) 143 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial Sept 19 1927

20 UNDERTAKER Wendell & Lipscomb ADDRESS 301 N Eden

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25667

CERTIFICATE OF DEATH.

E 25667

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1515 Lawrence St. 17th Ward)

2-FULL NAME Edward A Stapf

(a) RESIDENCE NO. 2503 Christian St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 9 mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (Write the word): Married

5a If married, Widowed, or Divorced — HUSBAND of (or) WIFE of: Mary Stapf

6 DATE OF BIRTH (month, day and year): Sept 16th 1866

7 AGE: Years 60 Months 9 Days 12 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): Meat Market

(c) Name of employer: Owner

9 BIRTHPLACE (city or town): Balto. Md

(State or country): U.S.A.

PARENTS

10 NAME OF FATHER: August Stapf

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Mary Stapf

(Address) 2503 Christian St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept. 15th, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gunshot wound in Head (Revolver) (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Finnegan M. D.

(Coroner)

1927 (Address) 2572 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial: Sept 19th 1927

20 UNDERTAKER: F. B. Wiseheart ADDRESS: 856 W. Balto St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25668

CERTIFICATE OF DEATH.

E 25668

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital Ward)

2-FULL NAME Robert L. Christie

(a) RESIDENCE NO. 2957 Fredrick St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lydia R. Christie

6 DATE OF BIRTH (month, day and year): May 4 1866

7 AGE: Years 61 Months 4 Days 11

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto

PARENTS

10 NAME OF FATHER: Michael Christie

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Rosa Dorman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Edgar N. Steinecker

(Address): 3509 Fred Road

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and Inquiry thereon and from the evidence obtained by said Inquest and Inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

, 19 27 (Address) Curtis Bay Balto Md.

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Sept 19 1927

20 UNDERTAKER: J. B. Wippert — ADDRESS: 1500 W Baltimore St.

Spec.—1-12-23—M&T—500 Bks.

Weaver.

E 25669

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 2255 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adele Greco

(a) RESIDENCE No. 5218 Denmore Av ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jame Weaver

6 DATE OF BIRTH (month, day, and year): 2-20-77

7 AGE — Years: 50 — Months: 7 — Days: 2 — If LESS than 1 day, hrs or min.: .....

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Frederico Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Welburne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records
(Address): JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept-1, 1927, to Sept 15, 1927, that I last saw h living alive on Sept 15, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Recurrent Sarcoma of the Uterus

(duration) ..... yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Jan 10, 1927

Was there an autopsy? yes

What test confirmed diagnosis? microscopic

(Signed) Raymond Wine, M. D.

9/16, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Thomas Cem

DATE OF BURIAL: Sept 17 1927

20 UNDERTAKER: Samuel Hemsley

ADDRESS: Balto

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25670

CERTIFICATE OF DEATH.

E 25670

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1533 N. Pulaski St., (Ward) 15-21

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Whitson

(a) RESIDENCE No. 1533 N. Pulaski St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret A. Whitson

6 DATE OF BIRTH (month, day, and year): June 22 1868

7 AGE — Years: 59 — Months: 2 — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: B & O. R R.

9 BIRTHPLACE (city or town) (State or country): Martinsburg W. Va

PARENTS

10 NAME OF FATHER: Geo. D. Whitson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rebecca Hayden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant: Mrs. Margaret A. Whitson

(Address) 1533 N. Pulaski St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1927, to Sept 15, 1927, that I last saw h[illegible] alive on Sept 15, 1927, and that death occurred, on the date stated above, at 8.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sym + symptoms

(Signed) [illegible] M. D.

9/17, 19[illegible] (Address) 543 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Sept 19 1927

20 UNDERTAKER: W. M. Tuckner & Sons

ADDRESS: Norfolk Va

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25671

CERTIFICATE OF DEATH.

E 25671

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1211 N. 42nd St. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Lincoln Tyson

(a) RESIDENCE NO. 1211 N. 42nd St. St. 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Laura A. Tyson

6 DATE OF BIRTH (month, day, and year) Jan. 21-1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pennsylvania R.R.

9 BIRTHPLACE (city or town) Carroll Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER William D. Tyson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Keturah Slater

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Francis L. Tyson

(Address) 1211 N. 42nd St.

15 Filed....., 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage. Contributory Arteriosclerosis.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. M. Hamilton M. D. (Coroner)

10/18, 1927 (Address) 1632 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Lebanon Cemetery Baltimore Md. Date of Burial Oct. 9 1927

20 UNDERTAKER Horace H. Burgee ADDRESS 3631 Falls Road

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25672

CERTIFICATE OF DEATH.

46 E 25672

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3336 Chestnut Ave ST., 13 WARD)

2-FULL NAME Ida May Albert

(a) RESIDENCE NO. 3336 Chestnut Ave ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene L. Albert

6 DATE OF BIRTH (month, day, and year) Feb. 28-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	50	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles T. Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Eugene L. Albert (Address) 3336 Chestnut Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1927

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to Sept 10, 1927, that I last saw her alive on Sept 1, 1927 and that death occurred, on the date stated above, at 9.25 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/17, 19 27 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Sept. 12 19 27
20 UNDERTAKER Horace K. Rutzee	ADDRESS 603 Fallsway

Spec.—1-10-21—M&T—1500 Bks.

25673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 25673

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 N Calvert ST. 17-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J Edgar Turner Sr

(a) RESIDENCE No. 1713 N Calvert ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Katherine G Turner

6 DATE OF BIRTH (month, day, and year): Feb 4 1880

7 AGE — Years: 47 — Months: 7 — Days: 12 — If LESS than 1 day, hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Commercial (Salesman)

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Durham N C

PARENTS

10 NAME OF FATHER: Andrew Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Durham N C

12 MAIDEN NAME OF MOTHER: Betty Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Durham N C

14 Informant (Address): Katherine G Turner 1713 N Calvert St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16 1927

17

I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to Sept. 16, 1927, that I last saw him alive on Sept 16, 1927, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Kidney

(duration) yrs. 2 mos 9 ds.

CONTRIBUTORY (Secondary): Carcinoma

(duration) yrs. 2 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Miles Atwater, M. D.

Sept 19 1927 (Address) 2129 W Mt Royal Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral County

DATE OF BURIAL: Sept 19 1927

20 UNDERTAKER: Robt J Turner

ADDRESS: 1147 N Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 25674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92E 25674

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1824 N Bond St. (E-1) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifford C. Littero

(a) RESIDENCE NO. 1824 N Bond St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ Agnes S. Litteros

6 DATE OF BIRTH (month, day, and year): July 23 - 1868

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cashier -

(b) General nature of industry, business, or establishment in which employed (or employer): Clerk & Sup. Courts Office

(c) Name of employer: Balto City

9 BIRTHPLACE (city or town) (State or country): Md Balto

PARENTS

10 NAME OF FATHER: Thos Littero

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Charlotte Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Agnes Littero
(Address): 1824 N. Bond St

15 Filed ..... 19 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12 - 1926 to Sept 16 1927, that I last saw him alive on Sept 16 1927, and that death occurred, on the date stated above, at 8.40 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis
Thrombosis.

CONTRIBUTORY (Secondary) Congestive Hypostatic Pneumonia (duration) 4 yrs. 4 mos. 36 hours.

18 Where was disease contracted if not at place of death? ~~Yes~~

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) George Abner Rawlins M. D.

1927 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Sept 19, 1927

20 UNDERTAKER: John O Mitchell & Sons ADDRESS: 1911 Eutaw Place

Spec.-7-17-26—A Co.—200 Bks.

E25675

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00125675

E 25675

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2007 Portugal St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Romecki

(a) RESIDENCE NO. 2007 Portugal St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 19. 27

7 AGE Years Months Days IF LESS than 1 day hrs. or min..

8 mo

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in whirh employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Joseph Romecki

11 BIRTHPLACE OF FATHER (City or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Frances Kozlowski

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Joseph Romecki

(Address) 2007 Portugal St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Sept 16, 27

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1927, to Sept. 16, 1927, that I last saw h(im) alive on Sept 12, 1927, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Rickets

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia ?

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Joseph Toohey M. D.

. 19 (Address) 600 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St Stanislaus Cem	Sept 19 1927
20 UNDERTAKER	**ADDRESS**
John A Oeler	1803 Bank St

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25676

129

REGISTERED NO. E 25676

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St 3-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Golde Borosky

(a) RESIDENCE NO. 3198 Edec St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac

6 DATE OF BIRTH (month, day, and year) Dec 1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
65	66	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Epstein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Jetta Goldie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Ida Blatsky

(Address) 1403 E Madison St

15 Filed....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-18 27. 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1927, to Sept 18, 1927, that I last saw h[illegible] alive on Sept 18, 1927, and that death occurred, on the date stated above, at 1036 m.

The CAUSE OF DEATH* was as follows:

Uremia & Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Askin. M. D.

9/19, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave — Date of Burial 9/19 1927

20 UNDERTAKER Sol Levinson - Bro — ADDRESS 1127 E Balto St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 25677

CERTIFICATE OF DEATH.

E 25677

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 838 E Patterson Park Ave ST., 12 WARD)

2-FULL NAME Marie M Robinson

(a) RESIDENCE NO. 838 E Patterson Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis C Robinson

6 DATE OF BIRTH (month, day, and year) May 6, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Lantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Catherine Bossell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Catherine Lantz (Address) 838 E Patt Park Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 27 to Sept 17 19 27

that I last saw h[illegible] alive on Sept 16 19 27

and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Nephritis, arteriosclerosis Hypertension Dropsy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) acute Ulc. Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? urbanna

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Fred Burgdorf M. D.

9-19-27 (Address) 80 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL Sept 19 27

20 UNDERTAKER [illegible] Cook ADDRESS 530 E North Ave

Spec.—1-12-23—M&T—500 Bks.

Sauer

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25678

CERTIFICATE OF DEATH.

E 25678

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Sauer

(a) RESIDENCE No. 100 Fremont Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie C. Sauer

6 DATE OF BIRTH (month, day, and year) May 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R R

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Nellie Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo F. Sauer

(Address) 100 Fremont Ave.

15 Filed ..., 19 27 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1927, to Sept 17, 1927, that I last saw h~~m~~ alive on Sept 17, 1927, and that death occurred, on the date stated above, at 11.10 A m.

The CAUSE OF DEATH* was as follows:

Appendicitis (Ruptured)
Peritonitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Tremid

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-12-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Laurence Fahnney M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Sept 20 1927

20 UNDERTAKER W M Cook

ADDRESS 507 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

E 25679 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25679
REGISTERED NO.

1-PLACE OF DEATH Volunteer's Hosp.

CITY OF BALTIMORE: (No. 418 W. Lexington St. 11-001 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick H. Weber.

(a) RESIDENCE NO. 10 Bancroft St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 22, 1885

7 AGE — Years: 42 — Months: — — Days: 20 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steam fitter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Reed-Dietz

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joseph Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Isabelle Deiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Joseph Weber
(Address) 3317 E. Monument St

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-17-27 19

17 I HEREBY CERTIFY, That I attended deceased from 9-15-27, 19, to 9-17-27, 19, that I last saw h[illegible] alive on 9-17-27, 19, and that death occurred, on the date stated above, at 4:30 A.M. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Clinical

(Signed) Jr Hella M.D. M. D.

9-17, 1927 (Address) 2214 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Sept 19 1927

20 UNDERTAKER: [illegible] Cook — ADDRESS: 2032 Woodbury

Spec.—1-12-23—M&T—500 Bks.

25680

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25680

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.) 530 St Georges Ave ST., 17 WARD

REGISTERED NO. 17-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alex Hilleary

(a) RESIDENCE No. 530 St Georges Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabel R Hilleary

6 DATE OF BIRTH (month, day, and year) Dec 27 1873

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
54	6	20 +	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Alex Hilleary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Jessamond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Isabel R Hilleary (Address) 530 St Georges Ave

15 Filed SEP 19 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1927, to Sept 17, 1927, that I last saw him alive on Sept 16, 1927, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Ch Int. Nephritis.
Ch - Myocarditis; Ascites.

(duration) 5 + yrs. mos ds.

CONTRIBUTORY (Secondary) Pyaemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. N. Bishop, M. D.

9/18, 1927 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Sept 20 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E North

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25681

90 E 25681

REGISTERED NO.

1. PLACE OF DEATH

City of BALTIMORE: (No. 1416 E. Lanvale Street St., 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Henry Thielemann

(a) RESIDENCE NO. 1416 E. Lanvale Street St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Martha Thielemann

6 DATE OF BIRTH (month, day, and year) Sept-1-1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	74	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Tailoring

(c) Name of employer None

9 BIRTHPLACE (city or town) Wolfhagen

(State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town) ? ?

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) ? ?

(State or country) Germany

14 Informant Mrs. Anna T. Knieland (daughter)

(Address) 1416 E. Lanvale Street

15 Filed [illegible] 1927 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 Sept. 17 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1926 to Sept. 17, 1927

that I last saw him alive on Sept. 16, 1927

and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? No

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock M. D.

. 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Cemetery	Sept-19-27 19
20 UNDERTAKER	ADDRESS
STEWART & BOWEN COMPANY	

Very Important. See Instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25682

CERTIFICATE OF DEATH.

114 E 25682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 N Central Ave ST. 8-18 WARD)

2-FULL NAME Howard S. Simms

(a) RESIDENCE No. 1404 N. Central Ave. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? 2 yrs. 7 mos. 3 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): 2 | 13 | 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles H. Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Edna Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Edna L. Abbott
(Address): 1404 N Central Avenue

15 Filed Apr 19 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1927, to Sept 16, 1927, that I last saw h~~e~~ alive on Sept. 16, 1927, and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) 2 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Impacted Colon

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas. Offutt, M. D.

, 19 (Address) 930 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 9/19/1927

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Ave

E 25683 HEALTH DEPARTMENT--CITY OF BALTIMORE 129 E 25683

CERTIFICATE OF DEATH

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 804 N Durham St 1-12 St.: WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Emma Poleduva

(Residence in Baltimore: No. 804 N Durham St St.: 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Unknown, 1 (Month) (Day) (Year)

7 AGE: 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: Housework (b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (State or country): Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Poleduva

(Address) 804 N Durham St

15 SEP 19 1927

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September 17 (Month) (Day), 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to. September 16 1927, that I saw h[illegible] alive on September 16, 1927, and that death occurred, on the date stated above, at 4.30 A.m. The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 5 yrs. mos. ds

Contributory (SECONDARY) Chronic Endo-myocarditis

(Duration) 3 yrs. mos. ds.

(Signed) Frank J. Ayd M. D.

September 17 1927 (Address) 2005 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer DATE OF BURIAL: Sept 20, 1927

20 UNDERTAKER: Fred Goodchild ADDRESS: Highland &

is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25684 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25684

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2437 Garret Ave ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Quinn

(a) RESIDENCE NO. 2437 Garret Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie E. Quinn

6 DATE OF BIRTH (month, day, and year) April 28, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	51	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City-

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer Conduits

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm. Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Nellie Quinn (Address) 2437 Garrett Ave

15 Filed SEP 19 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/17/27, 19, to 9/17/27, 19, that I last saw h[illegible] alive on 9/16/27, 19, and that death occurred, on the date stated above, at 5-45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Ch. Endocarditis.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) H. W. Sadler, M. D.

9/18/27 (Address) 321 E. 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Sept 20, 1927

20 UNDERTAKER Rita Mendelsohn & Son — ADDRESS [illegible]

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25685

E 25685

CERTIFICATE OF DEATH.

88-003

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital 20-69 Ward)

2-FULL NAME Joseph F. Kehoe

(a) RESIDENCE NO. 215 Edmondson Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race

5 Single, Married, Widowed, or Divorced. (write the word)

Male White Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27 1883

7 AGE Years 44 Months 2 Days 13

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Jos. F. Kehoe

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Jos. F. Kehoe

(Address) 215 Edmondson

Filed Sept 19 1927

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Accidental

(duration) yrs. mos. ds.

(Signed) C. J. Heuisler M. D.

(Coroner)

Sept. 19 1927 (Address) 25 W. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Sept 19 1927

20 UNDERTAKER Jos Jourdem & Son ADDRESS 217 S. Paca st

Srac—12-23-2—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25686 E 25686

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

City of BALTIMORE: (No. 805 E. Lakewood St. 13 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorain E. Szetela

(a) Residence No. 805 E. Lakewood St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 4-27

7-AGE. yrs. 5 mos. 15 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Szetela

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Lucian Barczak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Lucian Barczak

(Address) 805 E. Lakewood ave

15- Filed FEB 10 1927 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 18, 1927

17- I HEREBY CERTIFY, That I attended deceased from Sept. 16 1927 to Sept. 18 1927 that I last saw her alive on Sept. 16 1927 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Entero - Colitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Andrew Rundnick M D

, 19 (Address) 3525 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	Sept 19, 1927
20-UNDERTAKER.	ADDRESS
F.W. Ozazewski	1980 Eastern Ave

FEB 10 1927 COMMISSIONER OF HEALTH

Spec.—1-12-23—M&T—500 Bks.

Sunie Puskin

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25687

CERTIFICATE OF DEATH.

129 E 25687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5101 Denmore ave ST., 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sunie Ruskin

(a) RESIDENCE NO. 5101 Denmore ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Israel Puskin

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER William Stam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER ~~Ham~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Benjamin Puskin (Address) 1304 Eutaw Pl

15 Filed SEP 19 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept-16-, 1927, to Sept-18-, 1927 that I last saw h alive on Sept-18-, 1927 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis etc.

(Signed) Herman Seidel, M. D.

9/18 1927 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holeman Circle Hebrew Mt Carmel	9-19- 1927
20 UNDERTAKER	ADDRESS
Fast Service, 1439	E. Balto.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

113

E 25688

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 25688

REGISTERED NO._____

City of BALTIMORE: (No. 1009. N. Central ave 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Domenick Darone

(a) RESIDENCE NO. 1009. N. Central ave. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) april 23-1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER F. P. Darone

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Mary Maggio

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant F. P. Darone

(Address) 1009. N. Central ave.

15 Filed ..... 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/18 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to Sept 18, 1927,

that I last saw h[illegible] alive on Sept 17, 1927

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY .....

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis? .....

(Signed) Henry H. Weinberger M. D.

9/18, 1927 (Address) 1724 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial 9/19 1927

20 UNDERTAKER: Geo. J. Ruth ADDRESS 1735 Harford ave

Cor.—12-9-25—A Co.—200 Bks.

E 25689

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25689

CERTIFICATE OF DEATH.

167-001

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William H. Smith

(a) RESIDENCE NO. 216 S. Castle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Smith

6 DATE OF BIRTH (month, day, and year) Oct 10/1881

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Margaret Smith

(Address) 10[illegible] Castle St.

15 Filed....., 19.....

.....Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16/27 19[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Poisoning

(Suicide ?)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Green M. D.

(Coroner)

9/19/27 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Trinity Cemetery — Date of Burial Sept 20 1927

20 UNDERTAKER Williams Cook — ADDRESS 502 E North

Spec.—1-12-23—M&T—500 Blks.

E 25690

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25690

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1807 N. Chester ST., 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dietz

(a) RESIDENCE NO. 1807 N Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: John Dietz

6 DATE OF BIRTH (month, day, and year): Jan. 4th, 1853

7 AGE: Years: 74 Months: 8 Days: 12 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wien

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. J. Dietz (Address) 1807 N. Chester St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16 1927

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to Sept 16, 1927, that I last saw h[illegible] alive on Sept 16, 1927, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & General Senility (duration) 2 yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Postive

(Signed) Dr J W Kennard, M. D.

9-17-1927 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 9/17/1927

20 UNDERTAKER: E. J. Fanning & Son — ADDRESS: 1938 E. Lafayette Ave.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25691

E 25691

CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2123 Mt. Holly St. 15-61 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Bents

(a) RESIDENCE NO. 2123 Mt. Holly St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Bents

6 DATE OF BIRTH (month, day, and year) Oct 8" 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	60	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Geo C. Bents

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Sophia Schutte

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary M. Bents

(Address) 2123 Mt Holly St.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18" 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1927, to Sept 18 1927, that I last saw h— alive on Sept 18 1927, and that death occurred, on the date stated above, at 3.50 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

acute dilatation of Heart about 4 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) From history of coronary sclerosis about 6

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) M S Tulett, M. D.

(Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. Date of Burial Sept. 21" 1927

20 UNDERTAKER Geo. M. Fink & Son ADDRESS 811 N. Howard St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25692

CERTIFICATE OF DEATH.

X109-002

E 25692

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Joynes

(a) RESIDENCE NO. Street, Md. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 18/1919

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	8	6	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N.C.

PARENTS

10 NAME OF FATHER Arthur Joynes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Florence Graybu[illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.C.

14 Informant Arthur Joynes
(Address) [illegible] Street, Md.

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 18/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia - Tonsillar Abcess
Lung Abcess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. H. Cullen, M. D.
(Coroner)

9/19/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Darlington Cemetery Darlington Md. Date of Burial 9-20th 1927

20 UNDERTAKER: Herbert J. Bailey ADDRESS: Darlington Md.

Spec.–7-17-26—A Co.—200 Bks.

43407

E 25693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

131

E 25693

1-PLACE OF DEATH University Hospital REGISTERED NO. 25693

City of BALTIMORE: (No. ____ St. 16-68 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Frank J. Imhoff

(a) RESIDENCE NO. 743 Pillar Grove St. ____ Ward ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 43 Months ____ Days ____ IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Electrical Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Maryland
(State or country)

PARENTS

10 NAME OF FATHER Frank C Imhoff.

11 BIRTHPLACE OF FATHER (City or town) ____
(State or country)

12 MAIDEN NAME OF MOTHER Alba Debnoff.

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country)

14 Informant Hosp. Record.
(Address)

15 Filed ____, 19 ____ ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to Sept 18, 1927
that I last saw h[illegible] alive on Sept 18, 1927
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) 3 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) ____ yrs. ____ mos. 1 ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____

(Signed) L. A. Laumeier, M. D.
(Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: Sept 21 19[illegible]

20 UNDERTAKER: Harry M Armacost — ADDRESS: 1201 Hodgson Rd

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25694

CERTIFICATE OF DEATH.

113 E 25694

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7-9 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert H. Wopman

(a) RESIDENCE NO. 2008 McElderry St St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 14/27

7 AGE: Years — Months: 2 — Days: 4 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Christian Wopman

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Marion Vieweg

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto., Md.

14 Informant: Christian Wopman

(Address): 2708 Hedelberg St

15 Filed.....19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 18/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus- Acute Gastro-intestinal Indigestion

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Jos. Carter (Coroner) M. D.

(Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem — Date of Burial: Sept 20 27

20 UNDERTAKER: Wm E Fuller & Son — ADDRESS: 2554 Wilkens Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Cor.—12-9-25—A Co.—200 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25695

CERTIFICATE OF DEATH.

188-003

E 25695

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 6-9 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Vernon Fitch

(a) RESIDENCE NO. 206 N. Washington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Chas N. Fitch

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Naomi M. Lindsay

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Charles N. Fitch

(Address) 206 N. Washington St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 17/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & crushed Chest
Run over by automobile. Accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Allen, M. D.
(Coroner)

9/18/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial Oak Lawn Cemetery Sept 20 27

20 UNDERTAKER John Allriet ADDRESS 200 E Orleans

C. HARRISON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

WELFER

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25696

CERTIFICATE OF DEATH.

66

E 25696

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 290 Schroeder St. 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Welfer

(a) RESIDENCE NO. 390 Poplar St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): Nov 23 1882

7 AGE: Years 44 Months 9 Days 24 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Aug Welfer

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Wilhelmina Furhardt

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Mrs Marie Rosenfeld

(Address) 427 N Bethel St

15 Filed ....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and hour) Sept 17 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to his death

(Coroner or inquiry.)

at the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism (duration) 7 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

Sept 18 27 Signed G C Ladis M. D.

(Coroner) (Address) 143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery Date of Burial Sept 20 27

20 UNDERTAKER: Chandler

ADDRESS 2402 Orleans

Spec- 12-23-21- E.B.R.S.- 400 Bks.

E 25697 HEALTH DEPARTMENT—CITY OF BALTIMORE 105 E 25697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. 1129 N Milton Ave St. 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hamilton Henry Rebbeun

(a) Residence No. 1129 N Milton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 30-1917

7-AGE. 10 yrs. 1 mos. 18 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Hudson Rebbeun

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER. Martha L Solomon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Mrs Hudson Rebbeun

(Address) 1129 N Milton Ave

15- Filed ... 192 ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 18-27

17- I HEREBY CERTIFY, That I attended deceased from Sept 9-27 to Sept 18, 1927, that I last saw h[illegible] alive on Sept. 17, 1927, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Charles H Bubert M. D.

Sept 19, 1927 (Address) 1100 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL, Sept 21, 1927

20-UNDERTAKER. Donaldson ADDRESS 200 E Baltimore

Spec.—1-12-23—M&T—500 Blks.

E 25698

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25698

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (St.) (WARD)

2-FULL NAME William Horne

(a) RESIDENCE NO. 10 S. Carrollton Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adam Horne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Adam Horne 10 S. Carrollton Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1927, to Sept 18, 1927, that I last saw him alive on Sept 18, 1927, and that death occurred, on the date stated above, at 9.40/P m.

The CAUSE OF DEATH* was as follows:

Meningitis
(Pneumococcic)

(duration) yrs. mos 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Lumbar puncture Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Mignon G. Sweet, M. D.

9/19, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jessop's Lem Balto Co Md	Sept 19 1927

20 UNDERTAKER John O Mitchell ADDRESS N. Eutaw Place

Spec—12-23-21—E.B.R.S.—400 Bks.

E 25699

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25699

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 825 E-41st St., 4-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgeana Whitford London

(a) Residence No. 825 E 41st St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.)
Female	White	

5a-If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Charles W London

6-DATE OF BIRTH (month, day and year) March 14-1867

7-AGE. 60 yrs. 6 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Harford Co Maryland

PARENTS.

10-NAME OF FATHER, William Whitford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Harford Co. Maryland

12-MAIDEN NAME OF MOTHER, Anna Whitford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Harford Co Maryland

14- (Informant) C Harlan W London

(Address) 825 E 41st St

15- Filed ..... 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 17/27

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1927 to Sept 17 1927

that I last saw ~~him~~ her alive on Sept 17 1927

and that death occurred, on the date stated above, at 4 15 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis

Hemorrhage of Brain

(Duration) yrs. mos. 7 ds

CONTRIBUTORY (Secondary) Hardening of arteries

(Duration) 2 yrs. mos. ds

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) C. P. Harlan M. D.

9/18, 1927 (Address) 4901 Garrison Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 1927
London Park Cemetery	Sept 20

20-UNDERTAKER Hughes Funeral Home ADDRESS 1128 W Baltimore St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25700 E 25700

CERTIFICATE OF DEATH.

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Joseph Gretzel

(a) RESIDENCE No. Ravenswood, W. Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Anna Gretzel

6 DATE OF BIRTH (month, day, and year) 6-22-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER John Gretzel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Anna Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1927, to Sept 18, 1927, that I last saw him alive on Sept 18, 1927, and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Uremia.

History of prostatic trouble for several years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign prostatic hypertrophy (duration) 5-7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood urea.

(Signed) H. C. James, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
RAVENSWOOD WVA	Sept 19 1927

20 UNDERTAKER ADDRESS

Rhea & Hall Inc 1411 Broadway

Spec.—12-23—M&T—500 Bks.

E 25701 HEALTH DEPARTMENT—CITY OF BALTIMORE

41-007

E 25701

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. ... WARD)

2-FULL NAME Mrs. Catherine Sloane

(a) RESIDENCE NO. Church Home & Inf. ST. ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. J. Sloan

6 DATE OF BIRTH (month, day, and year): May 8 - 1842

7 AGE: Years 85 — Months 1 — Days 11 — If LESS than 1 day, hrs ... or min. ...

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Montgomery Co. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mr. Howard Adams

(Address): 114 Overlea Road

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19 1927

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1927, to Sept. 19, 1927, that I last saw h- alive on Sept 18, 1927 and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, general & cerebral

(duration) ?; yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) George B. Buel, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newark N.J. DATE OF BURIAL: Sept 20 19 27

20 UNDERTAKER: Frazer & Grant Inc ADDRESS: 144 W. Biddle

Cor.—12-9-25—A Co.—200 Bks.

Julia Maulsby

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25702

CERTIFICATE OF DEATH.

66 E 25702

1-PLACE OF DEATH

City of BALTIMORE: (No. Pronounced dead at St. Joseph Hospital St. 5-8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Maulsby

(a) RESIDENCE NO. 12 Painter's Court St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day.....hrs. or.....min.

about 45

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Police Dept.

(Address)

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 6/ 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an in quiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said in quiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Alcoholism

(Found at 381 Forrest St

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Patten M. D.

(Coroner)

9/1/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND Date of Burial 19

20 UNDERTAKER ADDRESS 927

Commissioner Health. SEP 1 1927

Cor.—12-9-25—A Co.—200 Bks.

Poindexter

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25703

CERTIFICATE OF DEATH.

90 E 25703

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 1612 Mulliken St. St., 69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Poindexter

(a) RESIDENCE NO. 1612 Mulligan St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 Color or Race Black

5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) (89)

7 AGE Years 36 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fertilizer Co

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Police Dept

(Address)

15 Filed _____, 19 _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 15/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Patton M. D.

(Coroner)

9/16/27 (Address) 208 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

Commissioner Health

UNIVERSITY OF MARYLAND
C. HAMILTON JONES, M.D.
SEP 1927

Spec.—7-17-26—A Co.—200 Bks.

E 25704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 124

E 25704

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md University Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Clarissa Neale

(a) RESIDENCE NO. Ellicott City Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 82 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md—

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md—

14 Informant: Hospital Record

(Address): University Hospital

15 Filed , 19 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1927, to Sept 19, 1927,

that I last saw her alive on Sept 19, 1927,

and that death occurred, on the date stated above, at 12:25 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia with cardiac dilatation

(duration) yrs. mos. One ds.

CONTRIBUTORY (Secondary) Empyema of Gall Bladder and Cholelithiasis

(duration) yrs. One mos. 10 ds.

18 Where was disease contracted if not at place of death? Ellicott City Md.

Did an operation precede death? Yes Date of Sept 15-'27

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) R. S. Anderson, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ellicott City Md

Date of Burial: Sept 1927

20 UNDERTAKER: Scott M. Starr

ADDRESS: Ellicott City

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

Spec.—12-9-25—A Co.—200 Bks.

E 25705

HEALTH DEPARTMENT—CITY OF BALTIMORE

Frank Reynolds

117 E 25705

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 8th Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME George Samuel Brendel

(a) RESIDENCE NO. 109 N. Castle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Brendel

6 DATE OF BIRTH (month, day, and year) March 8 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
36	31	6	6	9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dresser for Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Adam Brendell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Ritz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant John Brendell

(Address) 227 Aisquith ave

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1927, to Sept 17, 1927, that I last saw h.i.. alive on Sept 17, 1927, and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

(duration) .....yrs. .....mos. 12 ds.

CONTRIBUTORY (Secondary) General

Peritonitis (duration) .....yrs. .....mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 15, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Post mortem

(Signed) [illegible], M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer — Sept 20 1927

20 UNDERTAKER — ADDRESS

Wendell Ryffel & Son — 3918 Eastern

Spec.—1-10-21—M&T—1500 Bks.

E 25706

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25706

CERTIFICATE OF DEATH.

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3047 Huntingdon Ave WARD) 12-51

2-FULL NAME Fredericka Veditz

(a) RESIDENCE NO. 3047 Huntingdon Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Veditz

6 DATE OF BIRTH (month, day, and year): Apr 27 1860

7 AGE — Years: 67 Months: 4 Days: 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: William Veditz

(Address) 3047 Huntingdon Ave

15 Filed . . 19 . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17 1927

17 I HEREBY CERTIFY, That I attended deceased from June . 19 27 . to Sept 17 . 19 27.

that I last saw h[illegible] alive on Sept 17 . 19 27.

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

adeno-carcinoma of uterus.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Diabetes

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alfred Dr. M. D.

9/18. 1927 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: Sept. 20. 1927.

20 UNDERTAKER: Mrs. John M. Teufel & Son ADDRESS: 801 W. Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 25707

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25707

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 227 S Bethel ST. 3-4 WARD)

2-FULL NAME Nora Borkey

(a) RESIDENCE. No. 227 S. Bethel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ivory Borkey

6 DATE OF BIRTH (month, day, and year) March 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48	[redacted]			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath City

PARENTS

10 NAME OF FATHER John Drake

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

11 Informant Ivory Borkey (Husband)
(Address) 227 S Bethel St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 17th, 1927, to Sept 17th, 1927, that I last saw her alive on ..., 1927, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Harold Wimer, M. D.

, 19 (Address) 30 S Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Sept 20 1927
20 UNDERTAKER	ADDRESS
Robert Wilkins	1515 McElderry St

Spec.—1-12-23—M&T—500 Bks.

E 25708

HEALTH DEPARTMENT—CITY OF BALTIMORE E 25708

CERTIFICATE OF DEATH.

16-002

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 13-59 WARD)

2-FULL NAME Evelyn Johnson

(a) RESIDENCE NO. 2369 Druid Hill Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7-21-26

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	13	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City Maryland

PARENTS

10 NAME OF FATHER Alexander Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Anna Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14. 1927. to Sept. 17 1927.
that I last saw her alive on Sept. 17 . 1927
and that death occurred, on the date stated above, at 10 15 P. m.
The CAUSE OF DEATH* was as follows:

Dysentery - bacillary

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Blood and mucus in stool

(Signed) Allen Blakemore, M. D.

. 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 19 1927

20 UNDERTAKER Daniel Burton ADDRESS Balto

C. H. JACKSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25709

CERTIFICATE OF DEATH.

171

E 25709

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Belvidere Ave 16-22 St. _____ Ward)

2-FULL NAME Annie D. Fisher

(a) RESIDENCE NO. 600 Bruce St. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: James L Fisher

6 DATE OF BIRTH (month, day, and year): About 1856

7 AGE: Years: About 71 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer: General

9 BIRTHPLACE (city or town): _____

(State or country): Md.

PARENTS

10 NAME OF FATHER: _____

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: _____

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Maryland

14 Informant: Jas. L. Fisher

(Address): 600 Bruce St.

15 Filed _____, 19 _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an _____ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said _____ (Inquest, autopsy or inquiry) find that said deceased came to _____ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by laceration of throat

(duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (Secondary) Razor

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. F. Kneeburg M. D. (Coroner)

June 18 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death _____ yrs., _____ mos., _____ ds. In the State _____ yrs., _____ mos., _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem Date of Burial Sept 19 1927

20 UNDERTAKER: Daniel Easton ADDRESS 94 Mrs

Spec.—7-17-26—A Co.—200 Blks.

E 25710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124 E 25710

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 18-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Matthews

(a) RESIDENCE NO. 24½ Rock St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mollie matthews

6 DATE OF BIRTH (month, day, and year): May 24, 1889

7 AGE: 38 Years 3 Months 25 Days IF LESS than 1 day ..... hrs. or ..... min..

38

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 20

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Howard County, Md.

PARENTS

10 NAME OF FATHER William Edward matthews

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Mattie Miles

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: William matthews

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19 1927

4 am

17 I HEREBY CERTIFY, That I attended deceased from 9-17, 1927, to 9-19, 1927, that I last saw h[illegible] alive on 9-19, 1927, and that death occurred, on the date stated above, at 4 am m.

The CAUSE OF DEATH* was as follows:

Toxic Hepatitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Lobular pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) John Roberts Phillips, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem

Date of Burial: Sept 22 1927

20 UNDERTAKER: D. Emil Carton

ADDRESS 916

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25711

CERTIFICATE OF DEATH

75-02

E 25711

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 502 E 27 St. 9-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Martin

(a) RESIDENCE NO. 502 E 27 St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S. if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Morris H Martin

6 DATE OF BIRTH (month, day, and year): Feby 17/1843

7 AGE: Years 84 Months 7 Days 17 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Jerkes

11 BIRTHPLACE OF FATHER (City or Town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ellie Fawcett

13 BIRTHPLACE OF MOTHER (City or Town) (State or country): Baltimore Md

14 Informant (Address) 502 E 27 St: Morris H Martin

15 Filed . 19 Registrar: ARM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Sept 19- 1924

17 I HEREBY CERTIFY, That I attended deceased from about one Year to . 19 ., that I last saw her alive on about 2 or 3 weeks ago and that death occurred, on the date stated above, at 7-30 a. m.

The CAUSE OF DEATH* was as follows:

Paraplegia

(duration) 1 year mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. G. Brentes, M. D.

. 19 (Address) 6349 Gwynn Oak Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem't Sept 24 19 27

Date of Burial

20 UNDERTAKER: William Cook & Co

ADDRESS: E North Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25712

CERTIFICATE OF DEATH.

188-402

E 25712

1-PLACE OF DEATH

City of BALTIMORE: (No.) Hopkins Memorial Hospital St. Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Ehmling

(a) RESIDENCE NO. 4719 Harford re St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catherine Ehmling

6 DATE OF BIRTH (month, day, and year) Oct 12, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balt. Md.

PARENTS

10 NAME OF FATHER John A. Ehmling

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Catherine Ehmling

(Address) 4719 Harford Rd

15 Filed....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/17 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquest)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

Street Car Accident.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Morrison M. D.

(Coroner)

9/19, 192 7 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

National Cem 19

20 UNDERTAKER ADDRESS

Very Important. See reverse side for additional space.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Blks.

E 25713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25713

1-PLACE OF DEATH

City of BALTIMORE: (No. 1240 Hull St. 24-35 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Gangler.

(a) RESIDENCE NO. 1240 Hull St. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 21 yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Married.

5a If married, XXXXXXXXXXXXXX HUSBAND of XXXXXXXXXX Margaret Gangler.

6 DATE OF BIRTH (month, day, and year) March 4, 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Hungary.

PARENTS

10 NAME OF FATHER Michael Gangler.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Hungary.

12 MAIDEN NAME OF MOTHER Eva Haupt.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Hungary.

14 Informant Margaret Gangler.(wife)

(Address) 1240 Hull St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 17, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) [signature] (Coroner) M. D.

9/17. 1927 (Address) 1017 E. Charles st.

•State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. a. a. Date of Burial Sept 20 1927

20 UNDERTAKER Margaret G. Flynn ADDRESS 1922 Light St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25714

CERTIFICATE OF DEATH

129 E 25714

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 144 W. Fort ave St. 93-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie C. Craig

(a) RESIDENCE NO. 144 W. Fort ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Irwin R. Craig

6 DATE OF BIRTH (month, day, and year) Sept 20, 1900

7 AGE — Years: 26 — Months: 11 — Days: 26

IF LESS than 1 day.....hrs. or....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Max Stamm

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Keffler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Irwin R. Craig

(Address) 144 W. Fort ave

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 4th, 1927, to Sept 17th, 1927, that I last saw her alive on Sept 17th, 1927, and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation & Chronic fibrous myocarditis

(duration) — yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) Cancer of ovary

(duration) — yrs. — mos 14 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Otto Y. Leibell M. D.

(Address) 1234 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Loudon Park Cem. Date of Burial: Sept 20 1927

20 UNDERTAKER: M. J. Flynn ADDRESS: 1422 Light

very important. See instructions on back of certificates.

E 25715

1 PLACE OF DEATH

~~Canton~~ 3713 Benefit St

STATE OF MARYLAND
CERTIFICATE OF DEATH

E 25715

Registration Dist. No.

Village or City (No 3713 Benefit St (Ward) 16-37

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Scharman In City 50 yrs.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: 6 (Month) 14 (Day) 1856 (Year)

7 AGE: 71 yrs. 3 mos. 3 ds. If LESS than 1 day hrs. or min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed or (employer): 040

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: John Scharman

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Linderstrom

13 BIRTHPLACE OF MOTHER (State or country): Germany

I HEREBY CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Katherine Scharman

(Address) 3713 Benefit St

Filed 192 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 17 (Month) (Date) 1927 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 10 1927, to Sept 17, 1927, that I last saw h~~e~~ alive on Sept 17, 1927, and that death occurred on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Lewis Foltz M. D.

Sept. 19 1927 (Address) Sparrows Point Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In this State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Schwartze Center | DATE OF BURIAL: 9/20, 1927

20 UNDERTAKER: George F Ruth | ADDRESS: 1755 Hanlon Av

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Spec.—1-12-23—M&T—500 Bks.

Holden

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25716

CERTIFICATE OF DEATH.

E 25716

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 756 W Mulberry ST. ..... WARD)

2-FULL NAME Mary J Holden

(a) RESIDENCE NO. 756 W Mulberry ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Snell Holden

6 DATE OF BIRTH (month, day, and year): [illegible] 1867

7 AGE: 60 Years | Months | Days | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): Ch

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Accomac Co Va

PARENTS

10 NAME OF FATHER: Revell Briggs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Snell Holden
(Address): 756 W. Mulberry St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17 1927

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to Sept 17, 1927, that I last saw her alive on Sept 17, 1927, and that death occurred, on the date stated above, at 7.15 P m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Sept 21 1927

20 UNDERTAKER: John H. Bradenbaugh — ADDRESS 1027 [illegible]

Spec. 12-23—M&T—500 Bks.

E 25717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25717

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. 27-43 WARD)

2-FULL NAME Howard Frisch

(a) RESIDENCE NO. 9 Rockdale Avenue WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Pearl Frisch

6 DATE OF BIRTH (month, day, and year): Sept 9/87

7 AGE — Years: 39 | Months: 40 | Days: — | If LESS than 1 day, hrs. or min.: 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George Frisch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Gertrude Salisbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 18 1927

17 I HEREBY CERTIFY, That I attended deceased from August 17, 1927, to Septemb 18, 1927, that I last saw h[illegible] alive on Sept 18, 1927, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

gastric carcinoma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? yes Date of Aug. 17, 1927

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) Christopher Johnston, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk — DATE OF BURIAL: Sept 21 1927

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Orleans St

Spec. — 17-26 — A Co. — 200 Bks

E 25718

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 25718

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1618 Ruttland Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary K. Jones

(a) RESIDENCE NO. 1618 Ruttland Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Geo. T. Jones

6 DATE OF BIRTH (month, day, and year): Apr 14/54

7 AGE: Years 73 Months 5 Days 3

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: John Windsor

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Watkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Mrs. W. P. France

(Address): 1809 E. Baltimore St

15 Filed 9-17-27, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16/27 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1927 to Sept 16 1927, that I last saw h[illegible] alive on 19, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Primary)

(duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

9-17-27 (Address) 600 N. Duncan St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Deal's Island Somerset Co. Md

Date of Burial: 9/20 19 27

20 UNDERTAKER: Philip Herring

ADDRESS: 2016 Orleans St

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25719 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25719

CERTIFICATE OF DEATH 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 Longwood Rd St.) 27-53 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ella Coale

(a) RESIDENCE NO. 110 Longwood Rd ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Ellis Coale

6 DATE OF BIRTH (month, day, and year): 9/11/1857

7 AGE: Years 70 Months — Days 18 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Covington Kentucky

PARENTS

10 NAME OF FATHER: Hezekiah Baily

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lisbon Ohio

12 MAIDEN NAME OF MOTHER: Elizabeth Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Winchester Virginia

14 Informant: Cecil Van Hollen

(Address): 1 Crescent Road

15 Filed ..., 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-19 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to 9-19 1927,

that I last saw her alive on 9-18, 1927,

and that death occurred, on the date stated above, at 1:15 A m

The CAUSE OF DEATH* was as follows:

CEREBRAL HEMORRHAGE

ARTERIOSCLEROSIS

HYPERTENSION

(duration) — yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. L. [illegible], M. D.

, 19 (Address) 1129 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Sept 21 1927

20 UNDERTAKER: Henry H. Tenkins Sons & Conard

ADDRESS: Mitchell St

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25720

CERTIFICATE OF DEATH

E 25720

75-002

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] St. 36-7 Ward)

REGISTERED NO.

2-FULL NAME Marion V Rowles

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 218 De Clinton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~ Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Charles F. Rowles

6 DATE OF BIRTH (month, day, and year)

7 AGE 67 (?) Years Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Michael Shank

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Ochs ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-18 19[illegible]

17

I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1927, to 9-18, 1927 that I last saw her alive on 9-18, 1927 and that death occurred, on the date stated above, at 7 15 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis

Monoplegia Left arm (duration) 1 yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Hist & Examination

(Signed) C. Guerino Boyd M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: Sept 21 1927

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 25721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1883 E 25721

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. N. Balto General Hosp. St. 15-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Lorsner

(a) RESIDENCE NO. 1708 Allamont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Lorsner

6 DATE OF BIRTH (month, day, and year): Jany. 3/1858

7 AGE — Years: 69 — Months: 8 — Days: 15 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer): Retail Tobacco

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va.

PARENTS

10 NAME OF FATHER: Saml. Lorsner

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Augusta Blaustein

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mary Lorsner

(Address): 1708 Allamont St

15 Filed.....19.....

Registrar

very important. See instructions on back of certificate

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Pelvis

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Accidental accident

(duration) .....yrs. .....mos. .....ds.

(Signed) S. H. Hennessy M. D.

(Coroner)

1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL: Balto. Hebrew Cem. Date of Burial 9/20/1927.

20 UNDERTAKER: David Sondheim ADDRESS 118-20 W. Fayette Ave

Spec.–7-17-26—A Co.—200 Bks.

25722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. 25722

1-PLACE OF DEATH Maryland. U.M. Hospital. Eden Memorial Hwy 114

City of BALTIMORE: (No. Calvert & 33rd St. 4-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Claude Wise

(a) RESIDENCE NO. 1813 E. 29 st St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1 – 1918

7 AGE 8 Years 10 Months 18 Days

If LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Joseph Wise

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ethel Hayden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Ethel A Wise

(Address) 1813 E. 29th St

15 Filed ....., 19 .....

R.H.M., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1927, to Sept 19, 1927,

that I last saw h.. alive on Sept 19, 1927,

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Ulcerative Colitis,

(duration) 5 yrs. 1 mos. 19 ds.

CONTRIBUTORY (Secondary) Dehydration +

Malnutrition (duration) yrs. 1 mos. 19 ds.

18 Where was disease contracted

If not at place of death? In Maryland.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy.

(Signed) Palmer F.C. Wallace M. D.

9/19, 1927 (Address) U.M.H. Calvert & 33rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Sept 22 1927

20 UNDERTAKER: Robt J Turner — ADDRESS: 1442 Broadway

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPART

Cor.—11-9-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25723
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

14-001

REGISTERED NO. E 25723

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 920 Dukeman Court St. 11-24 Ward)

2-FULL NAME Geof Grau

(a) RESIDENCE NO. 920 Dukeman Court St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lucy Grau

6 DATE OF BIRTH (month, day, and year) Aug. 13, 1874

7 AGE: Years 45 | Months | Days 22 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundry Filer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer General

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo Grau

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Brown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant [illegible]
(Address) [illegible]

15 Filed Sept 29 1926 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17, 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident Fracture of Skull

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.
(Coroner)

Sept 29 1926 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State .yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial Sept 30 1926

20 UNDERTAKER Samuel Hensley ADDRESS 1716 N Bridge

IF DEATH occurred in a hospital or institution, or while the deceased was temporarily supplied. AGE should be stated very carefully and in plain terms, so that it may be known whether deceased was a minor or adult. The items relating to PARENTAGE are very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 25724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 25724

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 124 W Hamburg St. 23 Ward) 23-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Washington

(a) RESIDENCE NO. 124 W. Hamburg St. 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Washington

6 DATE OF BIRTH (month, day, and year): 1869 ~~58 Yrs~~

7 AGE: Years 58 Months - Days - IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Laundry

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Marion Hall

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Bessie Neal

(Address): 124 W Hamburg St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/17/1927

17 I HEREBY CERTIFY, That I attended deceased from 9/11/1927 to 9/17/1927 that I last saw h alive on 9/16/1927 and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

& Sub-ac nephritis (duration) about 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no. Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & Microscopical

(Signed) Jno B Wen M. D.

9/19/1927 (Address) 908 Shark St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial 9/20/27

20 UNDERTAKER: Samuel Hemsley ADDRESS 1711 Bolton

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25725 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25725

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 E. Eager ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hettie Harris

(a) RESIDENCE NO. 1732 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced, (write the word) Widow.

5a If married, widowed or divorced HUSBAND of (or) WIFE of George Harris

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 76				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER Saul Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Hester Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Rebecca Reynolds

(Address) 1732 E. Eager St.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17, 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1927, to Sept 17, 1927, that I last saw h— alive on Sept. 17, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Chronic Heart Disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evn

(Signed) W. L. Berry, M. D.

, 19.... (Address) 1510 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Grove Cemetery

DATE OF BURIAL Sept 20

20 UNDERTAKER Wm. R. A. Elliott

ADDRESS 1225 Eastern Ave.

Cor.—12-9-25—A Co.—200 Bks.

E. 25726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

† 1888

E 25726

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp 7 Ward)

REGISTERED NO.

2-FULL NAME Francis Marion Evans

(a) RESIDENCE NO. Edenburg Va St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Burtal Evans

6 DATE OF BIRTH (month, day, and year): March 7 1850

7 AGE — Years: 77 Months: 6 Days: 2

If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Edenburg

(State or country): Va

PARENTS

10 NAME OF FATHER: David Evans

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Walters

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Virginia

14 Informant: Alice Myrtle Evans

(Address): 543 N Convent Ave

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 19- 1927

17 I HEREBY CERTIFY, That I took Investigation of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained, and from Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary)

Sept 19- 1927 (Address) Curtis Bay

Thos B. Horton M. D.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edenburg Va — Date of Burial: Sept 20 1927

20 UNDERTAKER: H. Tavenner Sons — ADDRESS: Norfolk

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25727

CERTIFICATE OF DEATH.

104-002

E 25727

1-PLACE OF DEATH: West Balto Gen'l Hosp. (WARD) 28 13

CITY OF BALTIMORE, NO.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: George F. Strohmeyer

(a) RESIDENCE NO. 4713 Hamilton Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha E. Strohmeyer

6 DATE OF BIRTH (month, day, and year): Sept. 27 1880

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
46	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Himself

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Strohmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1927, to Sept 18, 1927, that I last saw h[illegible] alive on Sept 18, 1927, and that death occurred, on the date stated above, at 11.46 A.m.

The CAUSE OF DEATH* was as follows:

Vincent's angina

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): chronic alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms

(Signed) Morris D Cohen, M. D.

19 (Address) West Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: Sept. 21 1927

20 UNDERTAKER: Wm J Pickerell Sons

ADDRESS: Norfolk Va

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25728

CERTIFICATE OF DEATH.

31

E 25728

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 442 E Cross St. St. 24 33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sheldon

(a) RESIDENCE No. 442 E Cross St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Julia G. Sheldon

6 DATE OF BIRTH (month, day, and year) Apl 26 / 89

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
38	—	4	22	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work Candles

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John A. Sheldon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Dixon Sept 5, 1927

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Julia G. Sheldon (Address) 442 E. Cross St.

15 Filed ..., 19... By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1927

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to Sept. 1, 1927, that I last saw him alive on Sept 1, 1927, and that death occurred, on the date stated above, at 9.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) W. B. Smith, M. D.

(Address) 129 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 2/1927

20 UNDERTAKER Wilson Cook — ADDRESS 502 E Nord

Spec.—1-12-23—M&T—500 Bks.

Rutledge 1623 E Nott

HEALTH DEPARTMENT—CITY OF BALTIMORE

25729

CERTIFICATE OF DEATH.

REGISTERED No. E 25729

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 East 26th St. 9-4 WARD)

2-FULL NAME Maria H. Pickerton

(a) RESIDENCE No. 518 East 26th ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced (or) WIFE of James Pickerton

6 DATE OF BIRTH (month, day, and year) Nov 7 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co Md

PARENTS

10 NAME OF FATHER Cyphorus Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Robt H. Pickerton (Address) 518 East 26th St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/11, 1921, to 9/18, 1927, that I last saw h[illegible] alive on 9/18, 1927, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:-

Acute Bronchitis, arteriosclerosis & Chronic Nephritis

(duration) yrs. mos 3 ds 7

CONTRIBUTORY (Secondary) Heart Failure & Cystitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Arkansas

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Thos A Pentz, M. D.

, 19 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Sept 21 1927

20 UNDERTAKER William Cook — ADDRESS 502 E Nott

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25730

CERTIFICATE OF DEATH

49 V E 25730

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Md. Gen. Hosp. (St.) 6-16 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Piffendahl

(a) RESIDENCE NO. 1333 N. Milton ave (St.) Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18, 1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	33	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Wm H. Piffendahl

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mgt A Burke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs Margaret A Piffendahl

(Address) 1333 N. Milton ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1927, to Sept 19, 1927.

that I last saw h alive on , 1927.

and that death occurred, on the date stated above, at 4 10 A m.

The CAUSE OF DEATH* was as follows:

Secondary melanotic sarcoma of brain Meninges

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 9/6/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Dr Augustus Hurd Wilson M. D.

, 19 (Address)

*State the Disease Causing Death, or in Deaths From Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

Date of Burial Sept 21 1927

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 25731 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1822 Aisquith (St.) 9-18 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Mehr

(a) RESIDENCE NO. 1822 Aisquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND (or) WIFE of Mary C. Mehr

6 DATE OF BIRTH (month, day, and year) Oct 9th 1843

7 AGE — Years: 83 — Months: 11 — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rail Road Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Millersburg Pa

PARENTS

10 NAME OF FATHER: George Mehr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine Wilmath

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary C Mehr
(Address): 1822 Aisquith st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1927, to Sep 19, 1927, that I last saw h alive on Sep 19, 1927, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Uremic intoxication

(duration) X yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 30 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs

(Signed) Otto H Duke M. D.

9/29 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Sept 22 1927

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1116 Hanover

Spec.—1-10-21—M&T—1500 Bks.

E 25732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 N. Potomac St. 6-11 WARD)

2-FULL NAME Margaret Mathison

(a) RESIDENCE No. 100 N. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of: George Mathison

6 DATE OF BIRTH (month, day, and year): Apl 20-1861

7 AGE: Years 76 Months 4 Days 27 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Reinwalt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): James Mathison 100 N Potomac St

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 13 - 1927, to Sept 17 1927, that I last saw h- alive on Sept 17 - 1927 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Senile - Cardio - Vascular Sept.

(duration) 4 yrs. ; mos - ds.

CONTRIBUTORY (Secondary) General Exhaustion -

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Franklin Bruner, M. D.

19 (Address) 125 S. Broadway -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: 9/21/1927

20 UNDERTAKER: J. J. Moran — ADDRESS 3 E. Balto St.

C. HAMILTON JONES, M. D.
Per

Spec.—1-12-23—M&T—500 Bks.

E 25733

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25733

CERTIFICATE OF DEATH.

REGISTERED NO. 1562 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3804 Egerton Road ST., WARD)

2-FULL NAME Joseph Edward Amos.

(a) RESIDENCE NO. 3804 Egerton Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	widowed

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Minnie Amos

6 DATE OF BIRTH (month, day, and year) Mar. 2. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Assistant Foreman

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER John Amos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co.

12 MAIDEN NAME OF MOTHER Julia Nonnemacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co.

14 Informant Miss Effie Amos (Address) 3804 Egerton Road.

15 Filed . . , 19 . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1 , 1927, to Sept 1, 1927, that I last saw h alive on Sept 1, 1927, and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Sen. Pneumonia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Jane Brown M. D.

1927 (Address) 1837 Fenna ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery Frederick Balto Co. Md. DATE OF BURIAL Sept 2, 1927

20 UNDERTAKER Harlen Stern Nonnemacher ADDRESS 3rd Belair Road

Spec—12-23-21—E.B.R.S.—400 Blks.

E 25734

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25734

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. 716 E. 41st St. 9-47 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Henderson

(a) Residence No. 716 E. 41st St.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Capt Chas J. Henderson

6-DATE OF BIRTH (month, day and year) Sept 18-1851

7-AGE. 76 yrs. — mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Jas L. Clogg

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Ruth Moore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Chas L. Henderson

(Address) Washington D.C.

15- Filed ....., 192.... Registrar. ASeal

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 19-1927

17- I HEREBY CERTIFY, That I attended deceased from June 2, 1927 to Sept 19, 1927.

that I last saw h— alive on Sept 18, 1927.

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chr. Int. Nephritis, Chr. Myocarditis.

(Duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual findings

(Signed) S. W. Bishop, M. D.

Sept, 192 7 (Address) 5 W. Chesapeake

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. 9/21 1927

20-UNDERTAKER. Chas R. Brand & Son

ADDRESS 1911 N. Royal Ave

Spec.—1-12-23—M&T—500 Bks.

(Michael Roche)

E 25735

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25735

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST., WARD)

2-FULL NAME Roche, Michael

(a) RESIDENCE NO. 1907 Allegany ST., WARD —

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	wh	Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 4, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	62	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Steam Ships

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) R. I

PARENTS

10 NAME OF FATHER Thomas Roche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Emma Donny.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) 418 Marine Hosp. Canton

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1927

17

I HEREBY CERTIFY, That I attended deceased from 5-24, 1926, to 9-19-1927 that I last saw h~~im~~ alive on 9-19-, 1927 and that death occurred, on the date stated above, at 11:25 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary Chronic, active, far advanced

~~Contributory~~ Secondary mos ds.

CONTRIBUTORY (Secondary) Tuberculous otitis media (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?..... —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Ralph Carton M. D.

9/19/1927 (Address) U.S. Marine Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys, Hampden

DATE OF BURIAL Sept 14, 1927

20 UNDERTAKER E. Leroy Stiffler

ADDRESS 1256 North ave

C. HARRISON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 25736 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25736

CERTIFICATE OF DEATH.

REGISTERED NO. 13-52/100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Home for Incurables ST. 40th WARD) & Cedar Ave.

2-FULL NAME Mrs. Louise T. Kiger

(a) RESIDENCE NO. Home for Incurables ST., 40th WARD & Cedar Ave.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE OF Jacob H. M. Kiger

6 DATE OF BIRTH (month, day, and year) Oct 17 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	76 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Otto Tarney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Kanderer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Mr. Louis C. Simon (Address) Baltimore Md

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-6-, 1927, to 9-20-, 1927, that I last saw h... alive on Sept 19 1927, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans over 5 yrs — mos — ds.
(duration)

CONTRIBUTORY (Secondary) Broncho pneum (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) W. W. Mayo M. D.

9/20 1927 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Sept 22 1927

20 UNDERTAKER Henry H. Jenkins Son & — ADDRESS Edmondson Ave

Spec.–7-17-26—A Co.—200 Bks.

E 25737

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25737.

CERTIFICATE OF DEATH

27-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Clay

(a) RESIDENCE NO. House of Good Shepard St. Ward Annapolis Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1911

7 AGE — Years: 16 — Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis.
(State or country) Md.

PARENTS

10 NAME OF FATHER Leon Clay

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant (Address) Hospital Records

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20/27 19

17 I HEREBY CERTIFY, That I attended deceased from 7/1/27 . 19 . to 9/20/27 . 19 .

that I last saw h-SY alive on 9/20/27 . 19 .

and that death occurred, on the date stated above, at 9 45 a.m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs 3½ mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. S. Winstead, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md

Date of Burial: Sept. 20 1927

20 UNDERTAKER: Joseph D. Warnick

ADDRESS: Annapolis Md.

Very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

E 25738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25738

REGISTERED NO. 83

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1902 E. Eager ST., 7-13 WARD)

2-FULL NAME Mary B. Elliott

(a) RESIDENCE NO. 1902 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Charles H. Elliott

6 DATE OF BIRTH (month, day, and year) July 28, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	49	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (own) Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John Fess

11 BIRTHPLACE OF FATHER (city or town) Frederick Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Christine Kruger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Chas. H. Elliott (Address) 1902 E. Eager St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. ..., 1926, to July 17, 1927, that I last saw her alive on July 17, 1927, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

Acute Softening of Brain

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. S. Marr M. D.

July 18 1927 (Address) 516 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	7/21/1927

20 UNDERTAKER E. J. Fanning & Son ADDRESS 1463 Battery Ave.

CHAMPION JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

E 25739

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25739

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 218 S Bond St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Pidenziano

(a) RESIDENCE NO. 218 S Bond St. Ward 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. If of foreign birth? 15 yrs. mos. ds.

very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Pidenziano

6 DATE OF BIRTH (month, day, and year): June 10 1896

7 AGE: Years 31 Months 3 Days 9 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Italy

(State or country)

PARENTS

10 NAME OF FATHER: Anthony Pidenziano

11 BIRTHPLACE OF FATHER (City or town): Italy

(State or country)

12 MAIDEN NAME OF MOTHER: Madella

13 BIRTHPLACE OF MOTHER (city or town): Italy

(State or country)

14 Informant: Minnie Pidenziano

(Address) 218 S Bond St

15 Filed ..... 19..... C. H. JOHNSON JONES, M. D.

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep 19 1927

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1927 to Sep. 19, 1927

that I last saw him alive on Sep. 18, 1927

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pearsons M. D.

Sep 20, 1927 (Address) 514 Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: H Kneent — Date of Burial: Sep 21 1927

20 UNDERTAKER: Wendell Offel & Son — ADDRESS 578 W

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25740

CERTIFICATE OF DEATH

31 E 25740

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1318 W. Lexington St. 16-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie C. Shea

(a) RESIDENCE NO. 1318 W. Lexington St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1898

7 AGE: Years 29 Months 4 Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerical

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): "

14 Informant: Silas B. Mills

(Address): 1318 W. Lexington St.

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept. 19 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. , 1926, to Sept. 18 , 1927, that I last saw her alive on Sept. 18 , 1927, and that death occurred, on the date stated above, at 4:20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings - X-ray

(Signed) Anthony V. Mancuso, M. D.

, 19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial: Sept. 21 1927

20 UNDERTAKER: John O. Mitchell ADDRESS: 1300 Eastern Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25741 — E 25741

CERTIFICATE OF DEATH.

REGISTERED NO. 184-003

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia F. Hihn

(a) RESIDENCE NO. 1514 Lakeside Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): November 24-1852

7 AGE: Years 74 Months 9 Days 26 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: John B. Hihn

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Rauch

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Baltimore Md

14 Informant: Mrs Lillie Reisinger

(Address): 1514 Lakeside Ave

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Fractured Skull

(Auto accident)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

Sept 20. 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk Cem Date of Burial Sept 21 1927

20 UNDERTAKER: Wm J Jackson Sons & Co ADDRESS

very important. See instructions on back of certificate.

SEP 20 1927 C. HARRISON JONES, M. D.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25742

E 25742

CERTIFICATE OF DEATH

REGISTERED NO. 38

1-PLACE OF DEATH

City of BALTIMORE: (No. 1645 Ellamont Ave. Ward) 16-67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella May Whore

(a) RESIDENCE NO. 1645 Ellamont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo A Whore

6 DATE OF BIRTH (month, day, and year): Oct 4 1869

7 AGE — Years: 57 Months: 11 Days: 16

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Samuel Hobbs.

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Howard Co Md

12 MAIDEN NAME OF MOTHER: Emma Lemmond

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Geo A Whore

(Address): 1645 Ellamont ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 20 19 1927

17 I HEREBY CERTIFY, That I attended deceased from ....., 1927, to ", 1927

that I last saw h[illegible] alive on Sept 19, 1927.

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

8 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Emma J Brown

Assigned by coroner

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? probably residence

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Serological tests

(Signed) Jos H Zeller, M. D.

Sept 20, 1927 (Address) 1123 Hopkins Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Grove Ellicott City Howard Co Md — Date of Burial: Sept 22 1927

20 UNDERTAKER: John O Mitchell Sons — ADDRESS: [illegible]

very important. See instructions on back of certificates.

CLARENCE C. CLARKSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

E 25743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 25743

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2140 W. North Avenue St., 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Ringgold Smith

(a) RESIDENCE NO. 2140 W. North Avenue St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 10 mos. 22 ds. How long in U. S. if of foreign birth? 60 yrs. 10 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Ann Smith

6 DATE OF BIRTH (month, day, and year) October-27-1866

7 AGE	Years	Months	Days	IF LESS than 1 day ___ hrs. or ___ min.
	60	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Selling 066

(c) Name of employer Retired

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Dorsey Smith

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Lusk

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Louisa A. Smith (wife)

(Address) 2140 W. North Avenue

15 Filed ___, 19___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

SEPTEMBER 18 1927.

17 I HEREBY CERTIFY, That I attended deceased from November –, 1924, to Sept. 18, 1927, that I last saw him alive on Sept 17, 1927, and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

CHRONIC INTERSTITIAL NEPHRITIS

(duration) 3 yrs. – mos. – ds.

CONTRIBUTORY (Secondary)

(doration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of –

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests.

(Signed) [illegible], M. D.

9/19, 1927. (Address) 1102 No. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn Cemetery	Sept-20-1927
20 UNDERTAKER	ADDRESS

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 25744

HEALTH DEPARTMENT—CITY OF BALTIMORE

166 E 25744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2237 E. Preston St St. 8-12 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frieda C. Schlesinger

(a) RESIDENCE NO. 2237 E. Preston St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William F. Schlesinger

6 DATE OF BIRTH (month, day, and year): May 7/1906

7 AGE: Years 21 Months 4 Days 12 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John Stewart

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Freda C. Specht

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Balto., Md.

14 Informant: Wm. F. Schlesinger

(Address): 2237 E. Preston St.

15 Filed_____ 19____ Per_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poisoning

Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Antecedent) .....yrs. .....mos. .....ds.

(Signed) J. H. Cater M. D.

(Coroner)

9/20/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cemetery Date of Burial 9 21 1927

20 UNDERTAKER: George J. Ruth ADDRESS 1735 Harford Ave

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 25745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 25745

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 1625 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Kuehn

(a) RESIDENCE NO. not given St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 13 / 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Billard room man

(c) Name of employer

9 BIRTHPLACE (city or town) md

(State or country)

PARENTS

10 NAME OF FATHER John Kuehn

11 BIRTHPLACE OF FATHER (City or town) Pa

(State or country)

12 MAIDEN NAME OF MOTHER Fannie

13 BIRTHPLACE OF MOTHER (City or town) Pa

(State or country)

14 Informant BALTIMORE CITY HOSPITALS

(Address)

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-21, 1927, to 9-19, 1927, that I last saw him alive on 9-19, 1927, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows: Acute & Chronic Myocarditis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Morphine addiction

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. findings

(Signed) C. Stevens Stone, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. Date of Burial Sept. 23 1927

20 UNDERTAKER Jos. J. Kerr ADDRESS 156 N. Luzerne

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25746

CERTIFICATE OF DEATH.

74-001

E 25746

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1403 N Charles ST. 12-19 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Aaron Morris Cohen

(a) RESIDENCE NO. 1403 N Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Fena Cohen

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE — Years: 60 — Months: — — Days: — — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Radish Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Hannah Weitzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Charles Cohen 1403 N Charles St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1927, to Sept 20, 1927, that I last saw h— alive on Sept 20, 1927, and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Hemiplegia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hemiplegia

(Signed) Charles F Block, M. D.

Sept 20, 1927 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fchar Northern ave — DATE OF BURIAL: Sept 21 1927

20 UNDERTAKER: J Fenwood Bro — ADDRESS 1127 E Balto St

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 25747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25747

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 888 W. Baltimore St. 18-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph O Shaffer

(a) RESIDENCE. NO. 888 W. Baltimore ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Minnie A. Bringmann

6 DATE OF BIRTH (month, day, and year) Oct 31-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigarmaker

(b) General nature of industry, business, or establishment in which employed (or employer) Prate Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant Minnie A. Shaffer

(Address) 888 W. Balto Street

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1927

17

I HEREBY CERTIFY, That I attended deceased from 13 Aug. 1927, to 18 Sept. 1927, that I last saw him alive on 17 Sept. 1927, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Consultation. Dr T. R. Boggs

(Signed) Horace W. Byers, M. D.

. 19 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 21 1927

20 UNDERTAKER H. S. Brauning Son — ADDRESS 517 W Edmondson st

Spec.—1-12-23—M&T—500 Blks.

E 25748 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25748

CERTIFICATE OF DEATH.

REGISTERED NO. 18-29/29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 902 W. Lombard ST. (WARD) 18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia T. Creighton

(a) RESIDENCE NO. 902 W. Lombard ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. W. Creighton Sr.

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ~~Welsh~~ Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget ~~Welsh~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Geo. W. Creighton Sr 902 W Lombard St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 19 27

17 I HEREBY CERTIFY, That I attended deceased from May 3rd. 19 27 to Sept. 18, 19 27, that I last saw h er alive on Sept. 18, 19 27 and that death occurred, on the date stated above, at 8:25 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 5 Yrs.

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cronkhite, M. D.

9/29, 19 27 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 9-22-1927

20 UNDERTAKER H. C. Brauningson

ADDRESS 517 N Schroeder St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25749

CERTIFICATE OF DEATH.

75-02

E 25749

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 504 Carrie St. (Ward) 19-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Johnson

(a) RESIDENCE NO. 504 Pennsylvania Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col'd

5 Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Johnson

6 DATE OF BIRTH (month, day, and year): Dont/Know

7 AGE: Years 62 | Months - | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Louise Hopkins

(Address) 504 N. Pennsylvania Ave

15 Filed , 19 RMJ. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 5th, 1927, to Sept 19th, 1927, that I last saw h[illegible] alive on Sept 15th, 1927, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows: Paralysis

Hypostatic Pneumonia (duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) 607 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cem — DATE OF BURIAL: Sept 22nd 1927

20 UNDERTAKER: A. Jones — ADDRESS: 111 S. Eden St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25750

CERTIFICATE OF DEATH.

16-22 96

E 25750

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No Mun Hosp St 16 Ward)

2-FULL NAME John C. H. Jenkins

(a) RESIDENCE NO. 2014 E. Lafayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Ne.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 23rd 1908

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
19	- 3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) Mechanical

(c) Name of employer Fleming & Ott Termine Heating Co

9 BIRTHPLACE (city or town) Thoroughfare

(State or country) Va

PARENTS

10 NAME OF FATHER B. F. Jenkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Howell

13 BIRTHPLACE OF MOTHER (city or town) London Co.

(State or country) Va

14 Informant Benjamin Jenkins

(Address) 2014 E. Lafayette Ave

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D.

SEP 21 1927

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocuted

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

(Signed) J. A. Gladden M. D.

9/21 (Address) 1436 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs.. ....mos.. ....ds. In the State ....yrs.. ....mos.. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk. Date of Burial Sept 21st 19 27

20 UNDERTAKER A. Jones ADDRESS, 111 S. Gilmor St

very important. See instructions on back of Certificate.

Spec.—12 9 25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

E 25751

REGISTERED NO. E 25751

1-PLACE OF DEATH

City of BALTIMORE: (No. 153 East — St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Rowland

(a) RESIDENCE NO. 153 East — St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) B. West Indies

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Yorkmoor

14 Informant Cassie Wales

(Address) 153 East St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1927 to Sept 18, 1927, that I last saw h.. alive on Sept 18, 1927, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

10 hours (duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Valvular heart disease

Syphilis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Edward Fiske, M. D.

9-19 1927 (Address) 1012 E monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Date of Burial Sept 21 1927

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 725 Ashland Ave

very important. See instructions on BACK of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

25752

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2413 W. North Ave. ST. 15-68 WARD

REGISTERED NO. 25752

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Miss Florence Pledge

(a) RESIDENCE. No. 2413 W. North Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ——— yrs. ——— mos. ——— ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) Feby 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Joseph H. Pledge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Emma Whitford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Miss Rose Pledge

(Address) 2413 W. North Ave

15 Filed ——— 19 ——— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1927, to Sept 19, 1927, that I last saw her alive on Sept 18, 1927, and that death occurred, on the date stated above, at 1050 m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) ——— yrs. ——— mos. ——— ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Hypertension

(duration) ——— yrs. ——— mos. ——— ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Geo. L. Wessig, M. D.

19 (Address) 4100 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	9/22/27 19

20 UNDERTAKER Forney & Sons ADDRESS 131 E. Eager

Cor.—12-9-25—A Co.—200 Bks.

E 25753 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25753

66

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2210 Eastern St. 1-3 Ward)

2-FULL NAME Charles E Riley

(a) RESIDENCE NO. 2210 Eastern St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 9 mos. 18 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bendena Riley

6 DATE OF BIRTH (month, day, and year): Dec 2nd 1874

7 AGE: Years 52 Months 9 Days 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Soldierer in

(b) General nature of industry, business, or establishment in which employed (or employer): Can Worked.

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Charles Riley

11 BIRTHPLACE OF FATHER (city or town): Balto.

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Josephine Briff

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country): Md.

14 Informant: Bendena Riley

(Address): 2210 Eastern ave

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 18 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cardiac Dilation

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) G C Slade M. D.

(Coroner)

(Address) 1438 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial: Sept 21st 1927

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 400 S Wolfe St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 25754

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25754

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26 Ward) 11-37 90

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Dalemar

(a) RESIDENCE NO. 3703 Gough St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1873

7 AGE Years 54 Months 6 Days 24 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Wm Dalemar

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Christiana Brockman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Wefelmeyer

(Address) 657 W. Franklin St

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

Sept 19 27 (Signed) G. C. Yoder M. D.

(Coroner)

(Address) 143 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery Date of Burial Sept 21st 1927

20 UNDERTAKER Lilly & Sons ADDRESS 433 S. Wolfe St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25755 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25755

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp ST., 76-2 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Dotterwich

(a) RESIDENCE No. 402 S. Bouldin ST., 26 WARD
(Usual place of abode)
Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Dotterwich

6 DATE OF BIRTH (month, day, and year) Sept. 7th 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	31	5	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Peter Dotterwich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Strackfus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Elizabeth Dotterwich
(Address) 402 S. Bouldin St

15 Filed ..... , 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15 , 1927, to Sept. 19 , 1927, that I last saw him alive on Sept. 18 , 1927, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:
Cardio Vascular Renal disease with hypertension
(duration) several years yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia & Cardiac failure (duration) yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Lawrence Fahney M. D. (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Sept 21st 1927
20 UNDERTAKER Lilly & Zeisel	ADDRESS 403 S. Mount St

SEP 21 1927 C. HAMPSON JONES, M.D.

Cor.—12-9-25—A Co.—200 Bks.

E 25756

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25756

CERTIFICATE OF DEATH.

21-29/88-002

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME MARY LEVICKAS

(a) RESIDENCE NO. 1315 Glyndon St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Levickas

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
~~48~~ 38				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hous Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania

(State or country)

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithvania

14 Informant John Levickas

(Address) 1315 Glyndon Ave.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Injury (Coroner, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Dr. Car Acc

Multiple Fractures

(Duration) yrs. mos. ds.

CONTRIBUTORY Shock

(Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

Sept 20/27 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer Sept. 22. 1927

20 UNDERTAKER — ADDRESS

John Greblianckas J G 423 S Paca St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 25757 HEALTH DEPARTMENT—CITY OF BALTIMORE 135

CERTIFICATE OF DEATH. E 25757

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (NO. ST. 19-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Philip Lerwig

(a) RESIDENCE NO. Waverly P.O. Anne Arundel Co. Md WARD

(Usual place of abode)

Length of residence in city or town where death occurred (yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (write the word) Married

5a If married, widowed, or divorced. HUSBAND of (or) ~~WIFE of~~ Rose

6 DATE OF BIRTH (month, day, and year) July 11 - 1860

7 AGE Years 67 Months 2 Days 8 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tele Telephone Co

(b) General nature of industry, business, or establishment in which employed (or employer) Storekeeper

(c) Name of employer C. & P Tel Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Lerwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1927, to Sept 19, 1927, that I last saw him alive on Sept 19, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy (Benign) of 2 years duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ~~Pneumonia~~ Septicaemia

a.f. (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris Myers M. D.

, 19 (Address) Johns Hopkin Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Sept 22 1927

20 UNDERTAKER George D. Smith ADDRESS 1532 Hollins

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25758 E 25758

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH 137 N. Chapel

CITY OF BALTIMORE: (No. 137 N. Chapel St. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lacy McCrary

(a) RESIDENCE NO. 137 N. Chapel St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9.19.27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Lucius McCrary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manning S.C.

12 MAIDEN NAME OF MOTHER Eubia Boykin

13 BIRTHPLACE OF MOTHER (city or town) Sumter (State or country) S.C.

14 Informant Mother
(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9.19 1927

17 I HEREBY CERTIFY, That I attended deceased from 9.19.1927 to 9.19.1927.

that I last saw he alive on 9.19.1927,

and that death occurred, on the date stated above, at 5:05 P.M.

The CAUSE OF DEATH* was as follows:

Prematura birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Berry, M. D.

19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Johnson Jones M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25759

CERTIFICATE OF DEATH.

66 E 25759

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 534 N. Fremont St. 17-24 Ward)

2-FULL NAME Betty Thomas

(a) RESIDENCE NO. 534 N. Fremont St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sanborn

6 DATE OF BIRTH (month, day, and year) March 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant _____

(Address) UNIVERSITY OF MARYLAND.

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation

(duration) ____ yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) [illegible] M. D.
(Coroner)

19 (Address) 2577 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 25760 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25760

101-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hosp St. 7-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bary Lacy

(a) RESIDENCE NO. 733 Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Bary Lacy

6 DATE OF BIRTH (month, day, and year): about 1896

7 AGE: Years: 31 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Factory

(c) Name of employer: Gardner

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed ....., 19 ..... Registrar

1926 JRR

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Alcoholism chronic

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) I. I. Kerr M. D.

(Coroner)

Sept 1, 19 27 (Address) 572 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs.. ..... mos., ... ds. In the State ..... yrs.. ..... mos.. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

3 very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND
MEDICAL SCHOOL
SEP 21 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25761

CERTIFICATE OF DEATH.

90 E 25761

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St., 1124 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Gibson

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	married

5a If married, widowed, or divorced
HUSBAND of Unknown
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) no other diag.

(duration) yrs. mos. ds.

(Signed) H. Hemming M. D.
(Coroner)

, 19 27 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER

ADDRESS

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 25762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 161-002 E 25762

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. Calvert & 33rd St. 42-44 Ward)

REGISTERED NO.

2-FULL NAME Baby Kauffman

(a) RESIDENCE NO. Waynesboro, Pa. St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year) Sept 20, 1927

7 AGE Years Months Days 2 / IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in whirh employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Waynesboro, (State or country) Pa.

PARENTS

10 NAME OF FATHER Oscar W. Kauffman

11 BIRTHPLACE OF FATHER (City or town) (State or country) Waynesboro, Pa

12 MAIDEN NAME OF MOTHER La Rue Wareheim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Waynesboro Pa.

14 Informant (Address) Waynesboro Pa

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Sept 21, 1927.

that I last saw h alive on Sept 21, 1927.

and that death occurred, on the date stated above, at 9 50 A m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Prolonged labor & trauma

(duration) yrs. mos 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James F. C. Williamson M. D.

9/31, 1927 (Address) U. M. H. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waynesboro Pa. Date of Burial 9/22/1927

20 UNDERTAKER H. E. Stover - Son ADDRESS Waynesboro Pa.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Stansbury
714 Park =

HEALTH DEPARTMENT—CITY OF BALTIMORE

25763

E 25763

CERTIFICATE OF DEATH.

+3

12-50

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 439 East 22nd St. 12 WARD)

2-FULL NAME Joseph Warren G. Garman Sr

(a) RESIDENCE NO. 439 East 22nd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Flora A Garman

6 DATE OF BIRTH (month, day, and year) Jan 17/51

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph W. C. Garman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Nancy Moody

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs Flora Garman

(Address) 439 East 22nd Street

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23 , 19 1 , to Sept. 20 , 1927 .

that I last saw h i alive on Sept 20 , 1927 .

and that death occurred, on the date stated above, at 5 P M m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung (Metastatic)

(Origin in tonsils)

Duration (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Dyspnoea

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Suspected

(Signed) H. H. Stansbury, M. D.

Sept 21 1927 (Address) 714 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Sept 23 1927

20 UNDERTAKER William Cook

ADDRESS 502 E 40th

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25764

CERTIFICATE OF DEATH

90 E 25764

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2332 E Fayette St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Davis

(a) RESIDENCE NO. 2332 E Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or ~~Divorced (write the word)~~: Widower

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~: Elizabeth Davis

6 DATE OF BIRTH (month, day, and year): May 25 1853

7 AGE: Years 74 Months 3 Days 25

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER: William Davis Sr

11 BIRTHPLACE OF FATHER (City or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Robert Brooks Son

(Address): Calhoun & Hollins sts.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to Sept 20, 1927, that I last saw h.. alive on Sept 19, 1927, and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Art Arterial Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency Pulmonary Edema

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Lloyd M. D.

9/21, 1927 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western cemetry — Date of Burial: Sept 22 1927

20 UNDERTAKER: Robert Brookeson — ADDRESS Cor Calhoun Hollins St.

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25765

CERTIFICATE OF DEATH

31 E 25765.

1-PLACE OF DEATH Pediatric Dispensary, University - Hosp — REGISTERED NO.

City of BALTIMORE: (No. 14-27 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie Ledson —

(a) RESIDENCE NO. 1518-W. Lexington St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, ~~Widowed~~, or Divorced, (write the word)
male	Black.	infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 31-1-1726

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
		11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Frank Ledson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Ella Ledson

(Address) 1518 W. Lexington St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1927, to Sept 20, 1927, that I last saw h alive on Sept 19, 1927, and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

(1) Pulmonary Tuberculosis —

(2) Tuberculous Pneumonia —

(3) Meningitis Tuberculosa —

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted at home —

if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & X-ray.

(Signed) Louis Ellis Taunton, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn Cem	Sept 21 19 27
20 UNDERTAKER	ADDRESS
Dent Easton	916 Eutaw

Check of certificates. See instructions on back of very important.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25766

CERTIFICATE OF DEATH.

E 25766

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH (a) Baltimore & Payson Sts

City of BALTIMORE: (No. German Aged Home Ward)

2-FULL NAME Christine Tretz

(a) RESIDENCE NO. German Aged Home St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Tretz

6 DATE OF BIRTH (month, day, and year): July 8 1847

7 AGE. Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
80	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER: Louis Ungelhoefer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER: Gertrude Lang

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant: German Aged Home Records

(Address) Balto & Payson Sts

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 21st 19 27

17

I HEREBY CERTIFY, That I attended deceased from Jan 1926 19~~27~~, to 9/21/27, 19....., that I last saw h.. alive on 9/20/27, 19....., and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Heath, M. D.

9/21, 1927 (Address) 1143 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial Sept 23rd 19 27

20 UNDERTAKER: Sept 23 Cook ADDRESS 1003 N. Calvert St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25767

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 S. Fulton Ave., ST. 19-28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthias A. Maczis

(a) RESIDENCE NO. 28 S. Fulton Ave., ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Augusta C. Nee(Ziedler)

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Maczis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Augusta K. Maczis
(Address) 28 S. Fulton

15 Filed ..... 19 .....

RHH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1927 to Sept. 19, 1927.

that I last saw him alive on Sept. 19, 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 3 Yrs.
Chronic Nephritis 3 Yrs.
Chronic Myocarditis 3 Yrs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. V. Cowdrey M. D.

9/20/27 (Address) 721 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Sept 22 1927

20 UNDERTAKER Harry H. Witzke ADDRESS 1516 W. Lanvale

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25768

E 25768

E 25768

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO. C

CITY OF BALTIMORE: (No. 406 N Hilton ST. 20-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Bateman

(Residence in Baltimore: No. 406 N Hilton St St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH. March (Month) 5 (Day), 1840. (Year)

7-AGE. 87 yrs. 6 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). A A Co Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Oberseider

(Address) 406 N Hilton St

15-

Filed ....., 191.... Registrar. R M F

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20 (Month) (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3 1927, to Sept 20 1927, that I saw h er alive on Sept 18 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edw Cunningham M. D.

9 20, 1927 (Address) 517 Septt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge

DATE OF BURIAL. Sept 22 1927

20-UNDERTAKER Leo Lienhoop Sons

ADDRESS 525 N Lyndhurst St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25769

CERTIFICATE OF DEATH.

90 E 25769

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (NO.) 5248 St Charles Ave (ST.) (WARD)

2-FULL NAME Amanda A Ayers

(a) RESIDENCE NO. 5248 St Charles Ave ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Schauff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sophie Elsroad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Wm. Leach

(Address) 5248 St Charles Ave

15 Filed ..... 19 RMC Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jul. 20- 1927

17 I HEREBY CERTIFY, That I attended deceased from Jun 1 1927 to Jul 20 1927, that I last saw h[illegible] alive on Jul 20 1927, and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute pulmonary Edema

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/VI. 1927 (Address) 211 W Mulberry [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem | DATE OF BURIAL Sept 22 1927

20 UNDERTAKER A. S. Marshall | ADDRESS 253 Woodland

Spec.–7-17-26—A Co.—200 Bks.

E 25770

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25770

CERTIFICATE OF DEATH

100-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1544 N Washington St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew P Neuberger Jr.

(a) RESIDENCE NO. 1544 N Washington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 22 1927

7 AGE: Years — Months 2 Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto (State or country) Md

PARENTS

10 NAME OF FATHER Andrew P Neuberger

11 BIRTHPLACE OF FATHER (City or town): Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Marie R Lange

13 BIRTHPLACE OF MOTHER (city or town): Balto (State or country) Md

14 Informant Mrs Andrew P Neuberger

(Address) 1544 N Washington St

15 Filed SEP 2 1927 19 Registrar R Rae

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 22 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/20, 1927, to 9/22, 1927, that I last saw him alive on 9/22, 1927, and that death occurred, on the date stated above, at 1 0 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross signs

(Signed) David Miller M. D.

(Address) 1509 E Baltimore

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Sept 25 1927

20 UNDERTAKER: Henry Hoech Son — ADDRESS: 1301 E Eager St

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

E 25771

CITY OF BALTIMORE: (No. 2801 St Paul St. 12-50 WARD)

REGISTERED NO. E 25771

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm T. Parrish -

(a) RESIDENCE NO. 2801 St Paul St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1842

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ... min.
85	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William B Parrish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore md

12 MAIDEN NAME OF MOTHER Angeline Shreve

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) William T Parrish 2801 St Paul St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19/27

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1927, to Sept-19, 1927, that I last saw h m alive on Sept-19, 1927, and that death occurred, on the date stated above, at 5-30P m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia (duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallace W. White Dr., M. D.

, 19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 22 1927

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25772

CERTIFICATE OF DEATH

74-001

E 25772

1-PLACE OF DEATH Colonial Hospital

REGISTERED NO. _____

City of BALTIMORE: (No. _____ St. 11-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Samuel Oberndorf.

(a) RESIDENCE NO. 1701 Bolton St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Oberndorf

6 DATE OF BIRTH (month, day, and year) Oct 16 - 1860

7 AGE: Years 66 Months 11 Days 6

IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country)

PARENTS

10 NAME OF FATHER Abraham Oberndorf

11 BIRTHPLACE OF FATHER (City or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Strauss

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany

14 Informant Sallie Oberndorf

(Address) 1701 Bolton St.

15 Filed _____, 19 _____ Registrar

SEP 22 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept. 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 19th, 1927, to Sept 21st, 1927, that I last saw h alive on Sept 21st, 1927, and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Coma & Pulmonary Edema

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death? In street

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Picture

(Signed) Julius Bialostosky, M. D.

. 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

Date of Burial 9/23 19 27

20 UNDERTAKER Chas. P. Kraus & Son

ADDRESS 1118 N. Howard ave

OF DEATH in plain terms, so that it may be properly classified. In certificates. very important. See instructions on back of c

Spec.—1-10-21—M&T—1500 Bks.

25773 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25773
REGISTERED NO.

1-PLACE OF DEATH 1504 Morrison Court 25-7716 1-002
CITY OF BALTIMORE: (No. Curtis Bay, Md. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Konnopik

(a) RESIDENCE NO. 1504 Morrison Court. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 21/27.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Curtis Bay, Md.

PARENTS
10 NAME OF FATHER Fred. J. Konnopik
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.
12 MAIDEN NAME OF MOTHER Agness Moriarity
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Fred. J. Konnopik
(Address) Curtis Bay, Md.

15 Filed ____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1927, to Sept. 22, 1927, that I last saw h in alive on Sept. 21, 1927, and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Inertia Uteri
Instrumental Delivery
(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) ------
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas. V. Brooke M. D.
, 19 (Address) Brooklyn Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept. 23 27
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light

IMPORTANT. See instructions on back of certificates. TION is very important.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25774

CERTIFICATE OF DEATH

129

E 25774

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 663 Pierce St. 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Scott

(a) RESIDENCE NO. 663 Pierce St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie C. Scott

6 DATE OF BIRTH (month, day, and year): Oct 31 1870

7 AGE — Years: 56 57 — Months: 10 — Days: 18 — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Tolbert Co

(State or country): Md

PARENTS

10 NAME OF FATHER: Tom Scott

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country):

14 Informant: Annie C. Scott

(Address): 663 Pierce St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 18 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2 19 27 to Sept. 19 19 27

that I last saw h[illegible] alive on Sept. 19 19 27

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal Disease.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted Home.

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) Dr. T. Carr M. D.

Sept. 19 27 (Address) 575 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. — Date of Burial: Sept 22 19 27

20 UNDERTAKER: Samuel H. Hensley — ADDRESS: Middle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25775 W. 129 E 25775

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 910 Fayette ST. (18-16 WARD)

2-FULL NAME Edna Harper

(a) RESIDENCE NO. 910 Fayette ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Harper

6 DATE OF BIRTH (month, day, and year): Oct 7-1894

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
33	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Thurston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mildred Thurston (Address) 910 Fayette St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 27 1927, to Sept 25 1927, that I last saw h[illegible] alive on Sept 19 1927, and that death occurred, on the date stated above, at 11:20 A.M. The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? NV

Did an operation precede death? NV Date of .....

Was there an autopsy?

What test confirmed diagnosis? .....

(Signed) C. Howard Hurst M.D.

9/24 1927 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: Sept 27

20 UNDERTAKER: Samuel Wensley — ADDRESS: 1 N Eddie

over

Spec.—1-12-23—M&T—500 Blks.

E 25776 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 25776

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 W. Camden ST., 77-30 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Giovanni Cinquegrani

(a) RESIDENCE NO. 124 W. Camden ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Josephine Cinquegrani

6 DATE OF BIRTH (month, day, and year) June 24 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Anthony Cinquegrani

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Anthony Cinquegrani
(Address) 609 S. Ponca St

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1927, to Sept 20, 1927, that I last saw him alive on Sept 20, 1927 and that death occurred, on the date stated above, at 9.45 P.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi DiStefano, M. D.

Sept 21 1927 (Address) 1407 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Sept 23rd 1927
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Gorsuch Ave

Spec.—1-12-23—M&T—500 Bks.

E 25777 HEALTH DEPARTMENT—CITY OF BALTIMORE 61 E 25777

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary, 6-9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Z Lushman

(a) RESIDENCE No. Fayetteville, ST. WARD N. C.
(Usual place of abode)
Length of residence in city or town where death occurred 12 hrs yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) 9/21/27

7 AGE	Years	Months	Days	If LESS than 1 day, 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Baby

(b) General natnre of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Samuel Z Lushman

11 BIRTHPLACE OF FATHER (city or town) Balt. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sugar

13 BIRTHPLACE OF MOTHER (city or town) Balt. Md.
(State or country)

14 Informant Samuel Z Lushman
(Address) 2238 Fayette

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/21 .1927. to 9/22/27 .1927.
that I last saw him alive on 9/21 .1927
and that death occurred, on the date stated above, at 5:10 A m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic dystrophic [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hyard Rosser, M. D.

9/22, 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natnre of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern-ave	9/23 1927
20 UNDERTAKER	ADDRESS
Jack Levin	1451 E Baltimore

Spec.—1-12 23—M&T—500 Bks.

E 25778 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 25778

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910 Madison Ave St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Bundy

(a) RESIDENCE NO. 1910 Madison Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ida Bundy

6 DATE OF BIRTH (month, day, and year) June 22 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Riven Bundy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Julia Wilson (daughter) 1910 Madison Ave

15 Filed 9/21 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 4, 1927, to Sept 19, 1927, that I last saw him alive on Sept 18, 1927, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. T. Young M. D.

9/21/1927 (Address) 1429 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Sept 22 27
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1425 Ashland Ave

D. C. 1927 — ANDERSON JONES, M. D.

Spec.-7-17-26—A Co.—200 Blks.

E 25779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 25779

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 105 N. Chapel St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Landing Jackson

(a) RESIDENCE NO. 105 N. Chapel St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Jackson.

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Annie Ramsey

(Address) 105 N. Chapel St.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2/1927

17 I HEREBY CERTIFY, That I attended deceased from 9/1, 1927, to 9/21, 1927, that I last saw her alive on 9/20/27, 19..., and that death occurred, on the date stated above, at 10:45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

and Nephritis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Passive Congestion of Liver (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Signs & Symptoms

(Signed) J. R. Blake M. D.

, 19 (Address) 924 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial Sept. 24 1927

20 UNDERTAKER Chas. H. Johnson ADDRESS 1 N. Chapel St.

very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25780

CERTIFICATE OF DEATH

44 E 25780

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 511 So. Durham St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ANASTAZYA HYBRZYNSKA,

(a) RESIDENCE NO. 511 So. Durham St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S. If of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Hybrzynski,

6 DATE OF BIRTH (month, day, and year) May 1-1860.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife, 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER Antony Nowak,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Frances Sliwinska,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Mrs. Mary Majewska, (Daughter)

(Address) 1900 Aliceanna St

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1927, to Sept. 20, 1927,

that I last saw her alive on Sept. 20, 1927,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver,

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Kruger, M. D.

, 19 (Address) 2627 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, St. Stanislaus Cem. Date of Burial Sept 23 1927.

20 UNDERTAKER M. J. Sadowski. ADDRESS 905 S. Ann

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

See Letter in File

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25781

1-PLACE OF DEATH

REGISTERED NO. E 25781

City of BALTIMORE: (No. 1615 John Street. St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie E. Devine.

(a) RESIDENCE NO. 1615 John Street. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female.	white.	widow.

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Ira. Devine.

6 DATE OF BIRTH (month, day, and year) April.10/18~~00~~. 67

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
~~61.~~ 60		5.	11.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work. 30

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at home.

9 BIRTHPLACE (city or town)

(State or country) New York.

PARENTS

10 NAME OF FATHER Martin Benton.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) New York

12 MAIDEN NAME OF MOTHER Sarah Benton.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York.

14 Informant Miss. Mrrtle Smith.

(Address) 1615 John Street.

15 Filed ....., 19 .....

Registrar

NK14

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September, 21/1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1927, to Sept 21, 1927, that I last saw her alive on Sept 20, 1927, and that death occurred, on the date stated above, at 3-00 A.m.

The CAUSE OF DEATH* was as follows:

Endocarditis.

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) M.K. Rubin, M. D.

9/22, 1927 (Address) 1103 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St.Marys P.E.Cem,Hampden — Date of Burial: Sept/24/1927

20 UNDERTAKER: J.Walter Davis — ADDRESS: 3307, Paine St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25782 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25782

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 422 E 26 d ST. 12 50 WARD)

2-FULL NAME Jefferson Walsh Sr

(a) RESIDENCE NO. 422 E 26 d ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Walsh

6 DATE OF BIRTH (month, day, and year) Jan 20 1860

7 AGE Years 67 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet

(b) General nature of industry, business, or establishment in which employed (or employer) makes

(c) Name of employer B. C. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jefferson Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Jefferson Walsh Jr 422 East 26 St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1927

17 I HEREBY CERTIFY, That I attended deceased from 9, 20, 27 5, 19 ..., to 9, 21, 27, 19 ..., that I last saw h[im] alive on 9/20/27, 19 ..., and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Hugh Carothers, M. D.

9/20/27 19 (Address) 321-E-20

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Sept 23 19 27

20 UNDERTAKER William Carson — ADDRESS Eastern

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25783

CERTIFICATE OF DEATH.

12 E 25783

REGISTERED NO.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No.) Calhoun & Fayette ST. 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Pearl Proctor.

(a) RESIDENCE NO. 2238 Mc Elderry ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of Mrs William Proctor.

6 DATE OF BIRTH (month, day, and year) July 10 77

7 AGE — Years: 50 — Months: 2 — Days: 10 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER Wm Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Francis Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Wm Proctor 2238 Mc Elderry

15 Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-1, 1927, to 9-20, 1927, that I last saw her alive on 9-20, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis.

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 9-7-27

Was there an autopsy? no

What test confirmed diagnosis? Operation.

(Signed) [illegible], M. D.

, 19 (Address) 1102 No. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem

DATE OF BURIAL: 9/24 1927

20 UNDERTAKER: Philip Henry

ADDRESS 2016 Orleans

1927 HUNSON JONES, M. D.

PRINTING IS VERY IMPORTANT. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

206 E 25784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. 18-26 WARD)

161-002
E 25784

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Handy

(a) RESIDENCE NO. 316 Arlington Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-26-27

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
7 weeks	1	25	

8 OCCUPATION OF DECEASED: infant

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Spencer Handy

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) N C

12 MAIDEN NAME OF MOTHER Carrie Johnson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) N C

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... , 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 19 27, to Sept 21, 19 27, that I last saw her alive on Sept 21, 19 27, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage

(duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Exam. spinal fluid

(Signed) H. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Sept 22 1927

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

Spec.–7-17-26—A Co.—200 Bks.

E 25785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001

E 25785

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 848 N Sharp St. 22-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Queen Elizabeth Parker

(a) RESIDENCE NO. 848 N Sharp St. 22 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 18 1921

7 AGE — Years: 6 Months: 1 Days: 13

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): N.C.

PARENTS

10 NAME OF FATHER: Frank Parker

11 BIRTHPLACE OF FATHER (City or town)

(State or country): N.C.

12 MAIDEN NAME OF MOTHER: Rachel Burdrage

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): N.C.

14 Informant: Frank Parker

(Address): 848 N Sharp St.

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 20th 1927, to Sept 21 1927, that I last saw her alive on Sept 21 1927, and that death occurred, on the date stated above, at 7:10 A.M.

The CAUSE OF DEATH* was as follows:

1. Broncho Pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Recurrent (Influenza)

Bronchitis (duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Sam Bowley M. D.

19 (Address) 1708 Sharp St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemtery — Date of Burial 9/22 1927

20 UNDERTAKER: Walter B. Spriggs — ADDRESS 139 W. Hamburg St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25786 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25786

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 74 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fritz Klemm

(a) RESIDENCE NO. 121 Rogers Av. Brooklyn ST., L. I. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Consulates Sec'y

(b) General nature of industry, business, or establishment in which employed (or employer) Govt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adolph Klemm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ursula Heingman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Family (Address) Johns Hopkins Hospital

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1927, to Sept. 21, 1927, that I last saw h[illegible] alive on Sept. 21, 1927 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, right cerebral glioma, non malignant

— (duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

— (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Brooklyn, N. Y.

Did an operation precede death? yes Date of Sept 21, 1927

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) I. R. Trimble, M. D.

9-22 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklin N. Y. DATE OF BURIAL Sept. 1927

20 UNDERTAKER Henry Sander & Sons Inc ADDRESS 1710 Fleet St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 25787.

CERTIFICATE OF DEATH

3/ E 25787.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1926 W Lexington St., St. 20-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob G. Hales,

(a) RESIDENCE NO. 1926 W Lexington St., St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida H., Hess (Thearle)

6 DATE OF BIRTH (month, day, and year) January 24, 1873

7 AGE	Years	Months	Days
	54	7	27

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Shalmaneser Hales

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Adeline Deal

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant John G. Hales (Address) 1926 W Lexington St.

15 Filed ..... 19 ..... Registrar ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1922 to Sept 20 1927

that I last saw him alive on Sept 18th 1927

and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Horace W. Bolyen, M. D.

19 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	Sept 23 1927

20 UNDERTAKER Harry A. Wiltzius & Son

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Eks.

E 25788

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2145 Wilkens ave. St., 20 Ward) Registered No. 100001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles G. Schoolden

(a) Residence No. 2145 Wilkens ave. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. 2 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 9, 1925

7-AGE.	If LESS than 1 day,
yrs. 2 mos. 12 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER, George W. Schoolden

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Gertrude Alice Blankline

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14- (Informant) Geo. W. Schoolden

(Address) 2145 Wilkens Ave

15-

Filed ..... 192.... Registrar.

APA

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 21/27

17- I HEREBY CERTIFY, That I attended deceased from Sept 19, 1927 to Sept 21, 1927 that I last saw h... alive on Sept 21, 1927 and that death occurred, on the date stated above, at 9 40 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(8-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. H. Isaacs M. D.

. 19 (Address) 2114 Wilkens ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mount Olivet Cemetery	Sept. 23, 1927

20-UNDERTAKER ADDRESS

George L. Schubert 2101 Eutaw St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25789

CERTIFICATE OF DEATH.

170 E 25789

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 3009 Weaver Ave St. 26-40 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anton Kley

(a) RESIDENCE NO. 3009 Weaver Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Katherine Kley

6 DATE OF BIRTH (month, day, and year) Aug 4/1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lithographic

(b) General nature of industry, business, or establishment in which employed (or employer) Artist

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Anton Kley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Katherine Kley

(Address) 3009 Weaver Ave

15 Filed_____ 19____ C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Sept 21/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage- Pistol shot wound- Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ill health (duration) yrs. mos. ds.

(Signed) J. H. Bolton M. D.

(Coroner)

19 9/22/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial 9/23/27

20 UNDERTAKER J. G. Doran ADDRESS 300 E Balt.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 25790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143 E 25790

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Linwood Ave ST.) (1-7 WARD)

2-FULL NAME Mamie M. Henning

(a) RESIDENCE NO. 119 S. Linwood Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick W. Henning

6 DATE OF BIRTH (month, day, and year) April 29, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Ott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lucilia Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frederick W. Henning

(Address) 119 S. Linwood Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21st 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1927, to Sept. 21, 1927, that I last saw her alive on Sept. 21, 1927, and that death occurred, on the date stated above, at 6.26 p m.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage

Miscarriage (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) due to natural Causes (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Surgical signs

(Signed) C. S. Beer, M. D.

9/22/27 (Address) 408 E Pat Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Sept 24, 1927
20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	1710 Fleet St.

TIONS is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25791

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3902 Hillsdale Road ST. 28-64 WARD)

2-FULL NAME Rachel A. Hammen

(a) RESIDENCE No. 3902 Hillsdale Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Michael J. Hammen

6 DATE OF BIRTH (month, day, and year): June 8/1856

7 AGE — Years: 71 — Months: 3 — Days: 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brooklynville Balto Co Maryland

PARENTS

10 NAME OF FATHER: Michael Eberod

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Susan Latham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Nellie E Hammen (Address) 3902 Hillsdale Road

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 22 1927

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1927, to Sept-22, 1927, that I last saw her alive on Sept-21, 1927, and that death occurred, on the date stated above, at 3 o'clock A. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

To my knowledge (duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances A. Carpenter M. D.

9-22 1927 (Address) 201 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lund Ridge Cemetery — DATE OF BURIAL: Sept 24 1927

20 UNDERTAKER: Harry H Armacost — ADDRESS: 4204 Ridgewood Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25792

66 E 25792

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1415 Eastern Ave (St.) 4 (Ward)

2-FULL NAME Chas Ross

(a) RESIDENCE NO. 1415 Eastern Ave St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	W.	M K

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M K.

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or ....min.
About	50	—	—	

8 OCCUPATION OF DECEASED M K

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) M K

(State or country)

PARENTS

10 NAME OF FATHER M K

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) M K

12 MAIDEN NAME OF MOTHER M K

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) M K

14 Informant A. D. Wolfe

(Address) 1415 Eastern Ave

15 Filed ..... 19 .....

1927 Dec 12 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ed Lawshow

(duration) ..... yrs. ..... mos. ..... ds.

Signed Sept 23 1927 Geo Elliot Ross M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albemarle N. C. Date of Burial Sept 29 1927

20 UNDERTAKER Wm C. Black ADDRESS 927 N. Broadway

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25793

CERTIFICATE OF DEATH

100.-001 E 25793

1-PLACE OF DEATH - On the way to hospital (University) REGISTERED NO.

City of BALTIMORE: (No. Sylvia Ct St. 1435 Ward)

2-FULL NAME ~~Baby girl~~ Smith

(a) RESIDENCE NO. 1532- William St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23-1927

7 AGE	Years	Months	Days
		5	29

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. md.
(State or country)

PARENTS

10 NAME OF FATHER Floyd Smith

11 BIRTHPLACE OF FATHER (City or town) ~~Balt.~~
(State or country) Cambridge md. ~~md.~~

12 MAIDEN NAME OF MOTHER Ruth Edward.

13 BIRTHPLACE OF MOTHER (city or town) madison
(State or country) md.

14 Informant Floyd Smith
(Address) 1532 William St

15 Filed ..... 19 .....

..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22- 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Sept 22 1927, 19 .....

that I last saw h~~e~~ alive on Sept 21, 19 27

and that death occurred, on the data stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia -

..... (duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos ..... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? H F Easley

(Signed) University Hospital, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Date of Burial 9-24 19 27

20 UNDERTAKER E & J Hark ADDRESS 115 E Fraser

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 25794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 25794

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St. 26-39 Ward)

REGISTERED NO.

2-FULL NAME Jeremiah Wayland

(a) RESIDENCE NO. 3318 E Balto St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 22 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10th 1866

7 AGE	Years	Months	Days
	61	8	6

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Robt. B. Wayland

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Susan Wayland

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant CITY HOSPITALS

(Address) [redacted]

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-15, 1927, to 9-20, 1927.

that I last saw him alive on 9-20, 1927.

and that death occurred, on the date stated above, at 11.00 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr Bronchitis

Emphysema

(duration) yrs. 1 mos ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) [redacted], 19 (Address) CITY HOSPITALS, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthews — Date of Burial Sept 23 1927

20 UNDERTAKER Frank V. Kepitone — ADDRESS 2515 E Baltimore

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 25795 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 216 S. B'way ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Augusta Dawson

(a) RESIDENCE No. 216 S. B'way ST., V WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? 59 yrs. 10 mos. 8 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Dawson

6 DATE OF BIRTH (month, day, and year): Oct. 29-1867

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mgr of Laundry

(b) General nature of industry, business, or establishment in which employed (or employer): 0861

(c) Name of employer: Mc Ginnis Laundry

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Louis Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Mader

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry L. Beck

(Address) 216 S. B'way

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1927

17 I HEREBY CERTIFY, that I attended deceased from Nov 5 1926 to Sept 21 1927

that I last saw h alive on Sept 20 1927

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis - hypertension -

(duration) yrs. 9 mos. 15 ds.

CONTRIBUTORY (Secondary): Cerebral hemorrhage -

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure

(Signed) George Abner Bowden, M. D.

9/23, 1927 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 9/24 1927

20 UNDERTAKER: Louis Heumann — ADDRESS: 32 S. B'way

TION is very important. See INSTRUCTIONS on back of Certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | E 25796

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1111 Wilmot St. 17-24 WARD)

2-FULL NAME James A. Clark

(a) RESIDENCE NO. 1111 Wilmot St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Color

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora Clark

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Co

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jack Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Laura Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Leon H. Clark

(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/11/27

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927 to Sept 7th 1927

that I last saw h alive on Sept 7th 1927

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows: Pul. tuberculosis

CONTRIBUTORY (Secondary) Exhaustion (duration) 6 yrs. mos. ds.

Work (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Clark, M. D.

(Address) 924 Mon. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md

DATE OF BURIAL: Sept 23 1927

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Eager

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25797

CERTIFICATE OF DEATH

31

E 25797

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Burley

(a) RESIDENCE NO. 513 Oxford st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Burley

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz. Holliday

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital records

(Address)

15 Filed , 19 Registrar

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1927, to Sept. 21, 1927, that I last saw her alive on Sept. 21, 1927, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Clinical

(Signed) Henry C. Smith, M. D.

9-21, 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Sept 23 1927

20 UNDERTAKER Daniel Easton ADDRESS 516 N

Spec.—1-12-23—M&T—500 Bks.

206184 E 25798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 E 25798

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 24 35 ST. / WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norma Smiley

(a) RESIDENCE NO. 1116 Hanbert St. East Balto ST. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb - 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		18		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Smiley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Ibery

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 27, to Sept 21, 19 27,

that I last saw h[illegible] alive on Sept 21, 19 27,

and that death occurred, on the date stated above, at 4:50 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Post pertussis)

(duration) yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary) Rickets, malnutrition

(duration) yrs. / mos. ds.

18 Where was disease contracted if not at place of death? 1116 Hanbert St. East Balto.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, Cem. DATE OF BURIAL Sept 23 1927

20 UNDERTAKER Chas H. Sforza ADDRESS 1501 E Fort Ave

Spec.—1-10-21—M&T—1500 Bks.

Julia Deluca. ✓

E 25799 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25799

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1133 N. Fremont. REGISTERED NO. 90

CITY OF BALTIMORE: (No. ~~Julia DeLuca~~ 10 ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia DeLuca

(a) RESIDENCE (Usual place of abode) No. 1132 N. Fremont ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Camillo DeLuca

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 23 | Months 4 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Geo Ballot

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Camillo DeLuca

(Address) 1133 N. Fremont St

15 Filed SEP 23 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to Sept 21, 1927, that I last saw h[er] alive on Sept 21, 1927, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs mos 5 ds.

CONTRIBUTORY (Secondary) Endocarditis, Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) J. H. Mundon, M. D.

, 19 (Address) 8 W. Fremont St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 24 1927

20 UNDERTAKER: John J. Fields — ADDRESS: 1200 W. Lombard

ATION IS very important. See instructions on back of certificate.

C. HAS[illegible]SON JONES, M.

Spec.—1-12-23—M&T—500 Blks.

E 25800 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25800

CERTIFICATE OF DEATH.

REGISTERED NO. 11-002 15-58

1-PLACE OF DEATH Hebrew Aged Home Levendale

CITY OF BALTIMORE: (No. Bellvedere & Greenspring Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dave Fineglass

(a) RESIDENCE No. 4019 Park Heights Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Agwd Home Records

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 22 - 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-20-, 1927, to 9-22-, 1927, that I last saw h alive on 9-22-, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Generalized arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. L. Lichtenberg, M. D.

9/23, 1927 (Address) 2202 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 9/23 1927

20 UNDERTAKER Jack Levin

ADDRESS 1439 Eutaw

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25801

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. E 25801

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 17 WARD)

2-FULL NAME Baby Robertson

(a) RESIDENCE NO. Bengies, Balto County Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 d yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 9/15/27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Joseph's Hospital

PARENTS

10 NAME OF FATHER W. E. Robertson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fork Balto. County

12 MAIDEN NAME OF MOTHER Elsie E. Sterling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bengies Balto. County

14 Informant Mrs E. Robertson (Address) Bengies Md.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/15, 1927, to 9/22, 1927, that I last saw him alive on 9/22, 1927, and that death occurred, on the date stated above, at 12.30 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature 6 Mos

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Hamma Fahney, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ebenezer M. E. Cemetery — DATE OF BURIAL Sept. 23, 1927

20 UNDERTAKER Fredk Eastman Sons — ADDRESS Fullerton

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25802

CERTIFICATE OF DEATH.

90 E 25802

REGISTERED NO.

1-PLACE OF DEATH 1704 Pierce St.

City of BALTIMORE: (No. Mary Conway St. 14-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Conway

(a) RESIDENCE NO. 1704 Pierce St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Robert Conway

6 DATE OF BIRTH (month, day, and year): Jan 1 1869

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
58	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 670

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto Md

PARENTS

10 NAME OF FATHER: unk

11 BIRTHPLACE OF FATHER (city or town)

(State or country): unk

12 MAIDEN NAME OF MOTHER: unk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): unk

14 Informant: Cora Ray

(Address) 1708 Pierce st

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-20 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-20, 1921, to 9-20, 1927, that I last saw h.. alive on 9-20, 1927, and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease Hypertension

Approx (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Hankin, M. D.

1/22 19 27 (Address) 1528 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — Date of Burial: 9 25 1927

20 UNDERTAKER: Joseph A Lively — ADDRESS 409 N Mount St

very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

25803 HEALTH DEPARTMENT—CITY OF BALTIMORE 25803.

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE—(a) NO. 1610 McCulloh ST. 14-20 WARD)

2-FULL NAME Ella Martha Berry

(a) RESIDENCE NO. 1610 McCulloh ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Maggie Smith (Address) 1610 McCulloch St

15 Filed ..... , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1927, to Sept 20, 1927, that I last saw h[illegible] alive on Sept 20, 1927, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos Woodruff M. D.

9-22 1927 (Address) 706 Fidelity Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem. | DATE OF BURIAL 1927

20 UNDERTAKER Edward Hemsley | ADDRESS 1[illegible] Eddy

Cor.—12-9-25—A Co.—200 Bks.

E 25804

HEALTH DEPARTMENT—CITY OF BALTIMORE

Harrigan

CERTIFICATE OF DEATH.

177 E 25804

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St., 9-18 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Therese Clare Harrigan

(a) RESIDENCE NO. 1606 Lamont Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 1925

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Francis Harrigan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Catherine McCl[illegible]

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Francis Harrigan

(Address) 1606 Lamont Ave

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192[illegible] Sept 21/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Strychnine Poisoning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Weller M. D.

(Coroner)

19 (Address) 9/23/27 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial 9/24 19 27

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 25805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

27-4 49 E 25805

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 Dunstance Road (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lavinia Lee Heller.

(a) RESIDENCE No. 310 St. Dunstance Road (WARD)
(Usual place of abode)
Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lake Adam Heller.

6 DATE OF BIRTH (month, day, and year) Feb 8/1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	64.	8	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER Daniel E. Diggs.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Eliza Diggs
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14
Informant Mrs. George M. White
(Address) 310 St Dunstance Road

15
Filed 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 19 27

17
I HEREBY CERTIFY, That I attended deceased from June 3 , 1927 , to Sept 21 , 1927
that I last saw h alive on Sept 20 , 1927
and that death occurred, on the date stated above, at 10-36 a. m.
The CAUSE OF DEATH* was as follows:

Osteosarcoma of lip

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Osteosarcoma of lip

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Typical Signs

(Signed) Geo. Heller, M. D.
9-22, 19 (Address) 1937 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Greenmount Cemetery — Sept 23 1927

20 UNDERTAKER — ADDRESS
George F. Ruth — 1735 Harford Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25806

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 5237 Queensberry Ave. ST., WARD)

REGISTERED No. E 25806

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Crocetti

(a) RESIDENCE No. 5237 Queensberry St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 1-4-1927

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nick Crocetti

11 BIRTHPLACE OF FATHER (~~city~~ or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Evangelina Duye

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1927, to Sept 22, 1927, that I last saw him alive on Sept 22, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Enteritis & Colitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 5237 Queensberry Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 9/23/1927

20 UNDERTAKER George F. Pute — ADDRESS 1735 Harford Ave

HAMPSON JONES, M.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 25807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 E 25807

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1035 S. Stark St St. 43-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Mercer

(a) Residence No. 1035 S. Stark St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 31

7-AGE, 20 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Basil Mercer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Emma Murry

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Basil Mercer

(Address) 1035 Stark St

15- Filed, 19

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-21-21

17- I HEREBY CERTIFY, That I attended deceased from Sept 9, 19 21, to Sept 21, 19 21, that I last saw h[illegible] alive on Sept 21, 19 21, and that death occurred, on the date stated above, at 3:25 Pm.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis Acute

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? NW

Did an operation precede death? NW Date of

Was there an autopsy? NW

What test confirmed diagnosis?

(Signed) H. Forte, M. D.

, 19 (Address) 65 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, W P Cemetery DATE OF BURIAL, Sept 24, 19 21

20-UNDERTAKER C. H. Brown & Son ADDRESS Normalby

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

E 25808

CERTIFICATE OF DEATH Govans

E 25808

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5003 Tioga Ave St.) (7-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Martin Crockett

(a) RESIDENCE NO. 5003 Tioga Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18 1910

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
17	16	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER William H Crockett

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Belle Martin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Mr William H Crockett

(Address) 5003 Tioga Ave (Govans)

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 27, to Sept 21, 19 27, that I last saw h in alive on Sept 21 19 27, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 3 Wks ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos 2 Wks ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J & E Wheaton, M. D.

, 19 (Address) 4205 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
London Park Cemetery	Sept. 24. 1927
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25809

CERTIFICATE OF DEATH. 38

E 25809

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospl

City of BALTIMORE: (No. Baltimore, Md. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Fenwick

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Cook

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Fred Fenwick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lettie Miles

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Balto City Hospls

(Address) Balto Md

15 Filed....., 19.....

Registrar

very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19,
9-20-27

17 I HEREBY CERTIFY, That I attended deceased from 9-10- 19 27 to 9-20 19 27

that I last saw him alive on 9-20- 19 27

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Serological

(Signed) Wally Scott Emerson M. D.

9/21 19 27 (Address) 501 Cathedral St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Co Md

Date of Burial: Sept 19 27

20 UNDERTAKER: Robt E. Williams

ADDRESS: 1515 McCulloh St

Spec.—1-12-23—M&T—500 Bks.

E 25810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 25810

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3105 Cedar Ave ST.) 13-51 (WARD)

2-FULL NAME Edith R. Sloat.

(a) RESIDENCE No. 3105 Cedar Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
~~HUSBAND of~~ or) WIFE of Edward G. Sloat

6 DATE OF BIRTH (month, day, and year) Jan 12 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Housewife~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edward G. Sloat
(Address) 3105 Cedar Ave

15 Filed ..... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1927, to Sept. 20, 1927, that I last saw her alive on Sept. 19, 1927, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frank H Smith, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Sept 23 1927

20 UNDERTAKER Chenowith Son

ADDRESS 3615 Chestnut Ave

Spec.—1-12-23—M&T—500 Bks.

E 25811

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25811

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2714 Bernard ST. 17-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelson Gay Little

(a) RESIDENCE NO. 2714 Bernard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 21, 1925

7 AGE: Years 2 Months 3 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Arthur Herman Little

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Laura V. Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Arthur H. Little

(Address) 2714 Bernard St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to Oct 23, 1927, that I last saw him alive on Oct 23, 1927, and that death occurred, on the date stated above, at 6 12 9 m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar, Double Colds 5 day (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs.

(Signed) H. D. Corbin, M. D.

, 19 (Address) 3201 Old Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: Oct 27 1927

20 UNDERTAKER: Brenower & Son ADDRESS: 3615 Gaudent Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25812
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

9

REGISTERED NO. E 25812

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2714 Bernard St. 12-51 WARD)

2-FULL NAME Harold Gilbert Little

(a) RESIDENCE No. 2714 Bernard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27 1926

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 2714 Bernard St
(State or country)

PARENTS

10 NAME OF FATHER Arthur Lemon Little

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ellen Gilbert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Arthur L. Little
(Address) 2714 Bernard St

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 19 27, to Aug 22, 19 27, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows: Whooping Cough, Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Bailey

, 19 (Address) 2310 Eutaw Pl., M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL Sept 7 1927

20 UNDERTAKER Thanhauser Bros

ADDRESS 3616 Eastern Ave

Spec.—12-9-25—A Co.—200 Bks.

E 25813 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 25813**

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 N. Caroline St., 1-13 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Harris

(a) RESIDENCE NO. 714 N. Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lana Harris

6 DATE OF BIRTH (month, day, and year): 9-10-1872

7 AGE: Years 55; Months; Days 19; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steward

(b) General nature of industry, business, or establishment in which employed (or employer): canning

(c) Name of employer: Curtis Bay Canning Co.

9 BIRTHPLACE (city or town):

(State or country): md

PARENTS

10 NAME OF FATHER: unk

11 BIRTHPLACE OF FATHER (city or town):

(State or country): unk

12 MAIDEN NAME OF MOTHER: unk

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): unk

14 Informant: Lana Stanley

(Address): 714 N. Caroline St.

15 Filed....., 19.....

Registrar

SEP 23 1927

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-19 1927

17

I HEREBY CERTIFY, that I attended deceased from 9-17, 1927, to 9-19, 1927, that I last saw him alive on 9-19, 1927, and that death occurred, on the date stated above, at 11½ 6 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Acute Dilatation of Heart

(duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Gastro Enteritis

(duration) .....yrs. .....mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

9/22 1927 (Address) 808 W Baraloga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial

Loudon Cemetery, Sept 23 1927

20 UNDERTAKER: Mrs. P. A. Elliott ADDRESS 1225 Eastern Ave

Spec.—1-10-21—M&T—1500 Blks.

E 25814 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 84

CITY OF BALTIMORE: (No. Fayette & Carlton ST.) 7-25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Lewis

(a) RESIDENCE NO. Deer Park ST. Maryland WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 35 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Bent Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bent Lewis
(Address) Deer Park, Md.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/22/27 19

17 I HEREBY CERTIFY, That I attended deceased from 8/30/27, 19, to 9/22/27, 19, that I last saw him alive on 9/22/27, 19, and that death occurred, on the date stated above, at 9 50 a m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cerebral Pressure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of 9/21/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) W Wallace Walker, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Deer Park Oakland Md. DATE OF BURIAL Sept 25 1927

20 UNDERTAKER Harry S Fitzke ADDRESS 53 Oakland

SECTION 15 DAYS AFTER DEATH

Spec.–7-17-26—A Co.—200 Bks.

E 25815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 25815

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 25 Dolphin St., 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Jane Williams

(a) RESIDENCE NO. 25 Dolphin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. A. Williams

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE: Years 71 Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore Co.,

(State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Crose

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Sophia Anderson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Wm A. Laurey

(Address): 25 Dolphin St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 31 1927. to Sept. 20th 1927.

that I last saw h.. alive on Sept. 20th 1927

and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Hemorrhage

(duration) yrs. 0 mos. 21 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas. Ebell, M. D.

. 19 (Address) 1 E Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt. Auburn Cem. Date of Burial Sept 22 1927

20 UNDERTAKER: Samuel Stansbury ADDRESS Madison

Very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 25816 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25816

CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4. Harris ave St. 27-41 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Ellen Livingston

(a) RESIDENCE. No. 4 Harris ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years Months Days If LESS than 1 day, 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER, Millard Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER, Mary Muth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Millard Livingston 4 Harris ave

15 Filed . 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1927, to Sept 23, 1927, that I last saw h[illegible] alive on Sept 23, 1927, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth of seven months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Farrell M. D.

9/27 1927 (Address) 37 N. Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 9/26/27

20 UNDERTAKER John Ullrich — ADDRESS 928 Eden

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25817

CERTIFICATE OF DEATH.

E 25817

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3935 Edmondson Ave ST. 16-24 WARD

2-FULL NAME Andrew Johnson

(a) RESIDENCE. No. 3935 Edmondson Ave ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth B. Johnson

6 DATE OF BIRTH (month, day, and year) June 9, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden.

PARENTS

10 NAME OF FATHER Not known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lillian Johnson
(Address) 3938 Edmondson Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan . 19 27. to Sept 21 . 19 27.

that I last saw him alive on Sept 20 . 19 27.

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Hypertension

and its complications (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Geo. L. Wood, M. D.

. 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	9/24/27

20 UNDERTAKER Geo Leimbach & Son — ADDRESS E. N. Leimbach

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

25818

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 1901 L 25818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3711 Gough St ST., 26-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Peters

(a) RESIDENCE NO. 3711 Gough St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. 3. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) December 31 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		8.	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) nil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Lee Peters.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Mary Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Julia Knowles (Address) 3711 Gough St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Sept 21, 1927, that I last saw h[illegible] alive on " 21, 1927 and that death occurred, on the date stated above, at 8 P.M. in

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) A Green, M. D.

9/27, 19 (Address) 408 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
E Baltimore Cemetery	Sept 23 1927
20 UNDERTAKER	ADDRESS
Wendell J Hippel	30 S Edwards

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25819 E 25819

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 218 Cola Spring Lane ST. WARD

2-FULL NAME George W Schmidt

(a) RESIDENCE NO. 218 Cola Spring ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 29 26

7 AGE: Years # | Months 11. | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John P Schmit

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Rose M Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): John P. Schmidt 218 Cola Spring Lane

15 Filed ..... 19 ..... Registrar

JKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 22 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 21st, 1927, to Sept 22, 1927, that I last saw her alive on Sept 22, 1927, and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Duncan, M. D.

Sept. 19 (Address) Walnut Hill Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilson Cem. Balto

DATE OF BURIAL: Sept 24 1927

20 UNDERTAKER: William Cook Co.

ADDRESS: 501 E Fayette

SEP 23 1927 C. HAXTON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 25820

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25820

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 Scott ST., 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William O Gregory

(a) RESIDENCE NO. 1223 Scott ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~: married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Gregory

6 DATE OF BIRTH (month, day, and year): July 21 1846

7 AGE: Years 81 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Gregory

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant (Address): Mary E Gregory 1223 Scott St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 22 1927

I HEREBY CERTIFY, That I attended deceased from 1-1-, 1927, to 9-22, 1927, that I last saw h alive on 9/22/27, 1927, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Brain, M. D.

, 19 (Address) 227 W Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Sept 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

Spec. -7-17-26—A Co.—200 Bks.

E 25821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

109-E 25821

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (Insp. 5-8 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tucker or Mary Jones

(a) RESIDENCE NO. 127 Exeter st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897 ?

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	30 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Distric of Columbia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 19 27 to Sept. 21 19 27

that I last saw her alive on Sept. 21 19 27

and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Vincents infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab & Clinical

(Signed) Henry C Smith M. D.

9-22, 1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

Date of Burial SEP 22 1927 19

20 UNDERTAKER Commissioner Health.

ADDRESS

Per Wm. E. WOODALL

Sept. 22 1927 Clinton Jones M.D.

4-30 ARH

Be sure to print in pencil. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25822 E 25822

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene L. Smith

(a) RESIDENCE NO. 212 N Carey St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 20 1842

7 AGE: Years 65 Months 5 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kinston N. C.

PARENTS

10 NAME OF FATHER: Isaac Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Christian Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Leon L. Smith

(Address): Franklin Square Hospital

15 Filed . 19 ... Registrar

CHARLTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/22/21 19

17 I HEREBY CERTIFY, That I attended deceased from 9/14/21, 19 , to 9/22/21, 19 ,

that I last saw h[e] alive on 9/22/21, 19 ,

and that death occurred, on the date stated above, at 1.38 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis & Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical Signs.

(Signed) William H. Hardy, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: 9/25 19 21

20 UNDERTAKER: Robert Robertson

ADDRESS: Calhoun & Fayette

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 25823

CERTIFICATE OF DEATH

E 25823

1-PLACE OF DEATH Baltimore City Hospital

REGISTERED NO.

City of BALTIMORE: (No.) Balto, Md. (Ward) 15-16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas C. Blake

(a) RESIDENCE NO. 837 W. Fayette St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass

(b) General nature of industry, business, or establishment in which employed (or employer): Salesman

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) S. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospitals

(Address) Balto Md.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

9-22-'27

17

I HEREBY CERTIFY, That I attended deceased from 9-20- 1927 to 9-22- 1927

that I last saw him alive on 9-22- 1927

and that death occurred, on the date stated above, at 1101 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Alcoholic Psychosis, Acute Alcoholic Delirium

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Harry [illegible] M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Spartanburg S. C. Date of Burial 9/23 19 27

20 UNDERTAKER: Jack Leid ADDRESS 1439 E. Baltimore

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25824 E 25824

CERTIFICATE OF DEATH.

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hosp ST. 16-22 WARD)

2-FULL NAME Sarah Morris

(a) RESIDENCE NO. 1008 N. Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry A Morris

6 DATE OF BIRTH (month, day, and year): [illegible]-22-18[illegible]

7 AGE: Years 62 Months 6 Days 1 If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Solomon Drucker

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rachel

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant (Address): Harry A Morris 1008 N Monroe St

15 Filed , 19 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1927, to Sept. 23, 1927, that I last saw her alive on Sept 23, 1927, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma head of pancreas with ulceration of intestine

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acidosis & Cardiac failure (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Laurence Hahn M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dalto Helvesen Cem DATE OF BURIAL 9/25 19 27

20 UNDERTAKER: Jack Lewis ADDRESS 1439 Eastern

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25825

CERTIFICATE OF DEATH.

90 E 25825

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 1-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Schoolhouse

(a) RESIDENCE NO. Altamont Hotel St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1874

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
53	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Secretary

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Dan'l Schoolhouse

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophie Brown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Miss. Tracy Schoolhouse

(Address): Manchester Apts.

15 Filed....., 19.....

ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19

September 23, 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1927, to Sept 23, 1927, that I last saw h.. alive on Sept 23, 1927, and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardiovascular Disease.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Weinstein, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Chet Shalom Cem 9/25/1927

20 UNDERTAKER — ADDRESS

Hurd Sondheim 118-20 W. Mt. Royal Ave.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

No. 25826

CERTIFICATE OF DEATH.

74 501 E 25826

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Home for Incurables ST., 13-52 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Hellie Hammond

(a) RESIDENCE NO. Home for Incurables ST., 40th St & Cedar Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 24 - 1864

7 AGE — Years: 62 — Months: 8 — Days: 29 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Maryland

PARENTS

10 NAME OF FATHER: John Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Riordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Robt Real 3 N. 27th St

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9 - 22 - 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-26, 1927, to 9-22, 1927, that I last saw he alive on 9-21-, 1927, and that death occurred, on the date stated above, at 7.20 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary): Former Cerebral hemorrhage and hemiplegia

(duration) ..... yrs 8 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Wm J Mayo M. D.

9/22 1927 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 9/24 1927

20 UNDERTAKER: Chas F. Mauretson — ADDRESS: 118 W Mt Royal Ave

1927 HAMILTON John M

Spec.–7-17-26—A Co.—200 Bks.

E 25827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 25827

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2512 Fleet St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwinka Dereche

(a) RESIDENCE NO. 2512 Fleet St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S. if of foreign birth? 77 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Dereche

6 DATE OF BIRTH (month, day, and year): Oct 15 1854

7 AGE — Years: 47 Months: 11 Days: 7 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Poland (State or country)

PARENTS

10 NAME OF FATHER: Joseph Kathowshi

11 BIRTHPLACE OF FATHER (City or town): (State or country) Poland

12 MAIDEN NAME OF MOTHER: Catherine Zagrinska

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Poland

14 Informant: Agnes Dereche (Address) 2512 Fleet

15 Filed ....., 19.... Registrar

N.A.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1927, to Sept 23, 1927, that I last saw her alive on Sept 22, 1927, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ....yrs. ....mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Kraus, M. D.

(Address) 2627 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — Date of Burial: Sep 26 1927

20 UNDERTAKER: Wendell Diffel & Son — ADDRESS: 378 Hanover

very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25828 E 25828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Keyser Building ST. 15-63 WARD) REGISTERED NO. 24-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Rumsen

(a) RESIDENCE NO. 3 Prospect Circle ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? 77 yrs. 1 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia D. Rumsen

6 DATE OF BIRTH (month, day, and year) August-17-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Treasurer of
(b) General nature of industry, business, or establishment in which employed (or employer) Wm. Rumsen & Sons
(c) Name of employer (above)

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Rumsen

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Heply

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Virginia D. Rumsen (wife)
(Address) 3 Prospect Circle

15 Filed . . . . 192 . . . . Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Sudden (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

(Signed) (Coroner.) , M. D.

Sept. 22, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs., 1 mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Sept-24-27 192

20 UNDERTAKER STEUART & HOWEN COMPANY (WILLIAM F. WOOLEN, Successor) — ADDRESS 1024 N. NORTH AVE.

1927 HARRISON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25829

E 25829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Peach Alley ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Doris Snowden

(a) RESIDENCE NO. 1118 Peach Alley ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Snowden

11 BIRTHPLACE OF FATHER (city or town) Fairfield (State or country) Md.

12 MAIDEN NAME OF MOTHER Della Brightford

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant William Snowden

(Address) 1118 Peach Alley

15 Filed , 19 Registrat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24/1927

17 I HEREBY CERTIFY, That I attended deceased from 9/20/, 1927, to 9/24/, 1927,

that I last saw h alive on 9/24/, 1927

and that death occurred, on the date stated above, at 9.35 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Suspected & history

(Signed) [illegible] Baker M. D.

, 19 (Address) 709 Hearp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL 9/24 1927

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1731 Hanley St.

Cer.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25830

REGISTERED NO. E 25830

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. Ward)

2-FULL NAME John D'Orsky

(a) RESIDENCE NO. Sparrows Point Balto Co. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 46 Months about Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Steel

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town) (State or country) (Va) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Bethelem Steel Co. (Address) Sparrows Point, Md.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22-27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. of skull & fracture of pelvis

Shock & hem. Result Accident

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

Signed) W. C. Ewing (Coroner) M. D.

1-25-27 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oshawa, Ont. Canada Date of Burial 1/24/1927

20 UNDERTAKER C. V. Fanning & Son ADDRESS 1938 E. Lafayette Ave.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25831

CERTIFICATE OF DEATH.

111- E 25831

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 848 Pierce ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Jones

(a) RESIDENCE NO. 848 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sara Jones

6 DATE OF BIRTH (month, day, and year) Sept 1, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	50		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Lena Pierce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alexandria Va

14 Informant (Address) 27 S Paca St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1927, to Sept 22, 1927, that I last saw him alive on Sept 21, 1927, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Blayney Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Sept 25, 1927

20 UNDERTAKER Mrs Kate R. Williams

ADDRESS 322 N. Schroeder St

FRONT is very important

Spec. 1-12-23 MAT—500 Blks. Meta Holmes Starke

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25832

CERTIFICATE OF DEATH.

185

REGISTERED NO. E 25832

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3207 Carlisle Ave. ST., 154 WARD)

2-FULL NAME Meta Holmes Starke

(a) RESIDENCE NO. 3207 Carlisle Avenue ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Starke

6 DATE OF BIRTH (month, day, and year) June 13, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hammond (State or country) La.

PARENTS

10 NAME OF FATHER Edward P. Holmes

11 BIRTHPLACE OF FATHER (city or town) New Orleans (State or country) La.

12 MAIDEN NAME OF MOTHER Levinia Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) La.

14 Informant George W. Starke (Address) 3207 Carlisle Avenue

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21st, 1927, to Sept 23, 1927, that I last saw her alive on Sept 22, 1927, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism Ec following Chest injury by a fall. (Sudden death)

(duration) — yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary) Blow on chest from fall

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) S. E. Dodds, M.D.

Sept 23 1927 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 9/26 19

20 UNDERTAKER Henry H. Mears & Son

ADDRESS 805 N. Calvert

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25833
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31 E 25833
REGISTERED NO.

City of BALTIMORE: (No. 1405 N. Bruce St. 15-21 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Jackson

(a) RESIDENCE NO. 1405 N. Bruce St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jackson

6 DATE OF BIRTH (month, day, and year) About 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer General

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER David Jackson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Turner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Isaac Jackson
(Address) 1405 N. Bruce St.

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said autopsy
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage due to tuberculosis 1 yr

(duration) yrs. 5 mos. ds.

CONTRIBITORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. T. Kennedy M. D.
(Coroner)

Sept. 22, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery — Date of Burial: Sept 24 19 27

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Pulaski St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 25834

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

CERTIFICATE OF DEATH.

E 25834

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 1-11 Ward [redacted]

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Dorothy Lanham

(a) RESIDENCE NO. 2901 E. Monument St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18/1919

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	8	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James Earl Lanham

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Sparrow's Pt., Md.

12 MAIDEN NAME OF MOTHER Margaret Hagan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Mother

(Address) 2901 E. Monument St.

15 Filed_____ 19____ R.H.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidently struck by automobile
on Monument near Linwood
Fracture skull
(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
(duration) .....yrs. .....mos. .....ds.

Signed) John C. Weber, M. D.
9/23/27 (Coroner)
, 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

In place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Town — Date of Burial: Sept 24 1927

20 UNDERTAKER: Peter Nicolaus — ADDRESS: 2923 Eastern Ave

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25835

CERTIFICATE OF DEATH

E 25835

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH On way to Balto City Hosp. 1/2

City of BALTIMORE: (No. Lyndale St. N. 26-25 Ward)

2-FULL NAME Henry D. Meyers

(a) RESIDENCE NO. 3519 6 Loudon St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Meyer.

6 DATE OF BIRTH (month, day, and year) Jan. 1. 1881

7 AGE	Years	Months	Days 2/	IF LESS than 1 day ....hrs. or ....min.
	46	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Meyer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Enders.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Sybilla Meyer (Sister)

(Address) 411 N. Streeper St.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 22 192 7

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

No Indigestion

Time of Dur.

Duration yrs. mos. 1 hr

CONTRIBUTORY (Secondary) Acute and Dilatione

Dept 24/27 (Signed) J. C. Hades M. D.

19 (Coroner) (Address) 1438 Pine

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In (the State) yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery Date of Burial Sept. 25 19 27.

20 UNDERTAKER Henry Sander & Sons Inc ADDRESS 1710 Fleet St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25836 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-002

E 25836

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

2-FULL NAME George Cephas

(a) RESIDENCE NO. 612 Bradley St

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

ST., WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Cephas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rebecca Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Rebecca Cephas
(Address) 612 Bradley St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Sept 23, 1927, that I last saw him alive on Sept 23, 1927, and that death occurred, on the date stated above, at 5-30 p m.

The CAUSE OF DEATH* was as follows:

Nasal & Tonsillar Diphtheria

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Post. cult.

(Signed) Myron G. Tull, M. D.

9/24, 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL 9/24 1927

20 UNDERTAKER Daniel Easton (M.S.T.) — ADDRESS 916 Penna Ave

Spec.–7-17-26—A Co. 200 m.

E 25837

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25837

31

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 1559

City of BALTIMORE: (No. Baltimore City Hospitals St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Horman

(a) RESIDENCE NO. 2204 Pennsylvania ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ohio

PARENTS

10 NAME OF FATHER I. Horman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Amanda Jane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ohio

14 Informant Hospital Records

(Address)

15 Filed SEP 1927, 19 Registrar

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 27, 19, to Sept. 20 27, 19,

that I last saw him alive on Sept. 20, 19 27,

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Peritoneum

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema;

pneumonia (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Path. & Clinical

(Signed) Henry C. Smith M. D.

9-20 19 27 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

Date of Burial Sep 25 1927

20 UNDERTAKER James E. Bryski

ADDRESS 1364 N. Carey

Cor.—12-9-25—A Co.—200 Bks.

E 25838 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25838

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No 1735 Dennis Ave. Ward) 14-20

2-FULL NAME Estella A. Gibson

(a) RESIDENCE NO. 1736 Dennis Ave St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. _____ mos. _____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. F. A. Gibson

6 DATE OF BIRTH (month, day, and year): April 29, 1851

7 AGE: Years 44 Months 5 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____ (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Smith

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Tilbert

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Maryland

14 Informant: Geo. F. A. Gibson (Address) 1736 Dennis Ave.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) _____ yrs. 3 mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. T. Hennessy M. D. (Coroner)

1927 Address 1532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: 9-25 1927

20 UNDERTAKER: Mrs. George F. Holland — ADDRESS: 1631 Dinwiddie Ave.

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

Rice

E 25839 HEALTH DEPARTMENT—CITY OF BALTIMORE

90

CERTIFICATE OF DEATH.

E 25839

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicolas Rice

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St.

15 Filed ..... 19..... By ..... Registrar

very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22nd 1927

17

I HEREBY CERTIFY, That I attended deceased from No record ....., 19....., 10 ....., 19.....,

that I last saw h[illegible] alive on Sept 22, 1927,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic rheumatism

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Warner, M. D.

Md Sept 22, 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF HURIAL, CREMATION OR REMOVAL Cathedral Date of Burial Sept 26 1927

20 UNDERTAKER Rita Widefield ADDRESS 914 Fremont Ave

Spec.—1-12-23—M&T—500 Blks.

Kawacki

E 25840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 E 25840

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3241 O'Donell St ST. W-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony F Kawacki

(a) RESIDENCE NO. 3241 O'Donell St ST. / WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 1- 1905

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ..... min.
21	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Law Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Kawacki

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Michalina Joscinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: John Kawacki (Address) 3241 O'Donell St

15 Filed ....., 19 RLK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1927, to Sept. 22, 1927, that I last saw him alive on Sept. 22, 1927 and that death occurred, on the date stated above, at 5:05 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S. - Fat.

(Signed) John F. Szczbicki M. D.

, 19 (Address) 735 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem. DATE OF BURIAL: Sept 26 1927

20 UNDERTAKER: Stephen F Falkowski ADDRESS: 1000 Rowe

Spec.—12-9-25—A Co.—200 Bks.

E 25841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25841

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Av. St. 20-27 Ward)

2-FULL NAME John H. Massey.

(a) RESIDENCE NO. 400 N Fulton Av. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White.

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Etta Massey.

6 DATE OF BIRTH (month, day, and year) Aug. 21, 1853

7 AGE — Years: 74 — Months: 1 — Days: 2 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Virginia
(State or country)

PARENTS

10 NAME OF FATHER Wm. Massey.

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary Price.

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Virginia.

14 Informant Miss Etta Cuddy
(Address) 400 N. Fulton Av

15 Filed _____, 19____ _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Sept. 23, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1927, to Sept. 23, 1927, that I last saw him alive on Sept. 22, 1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

9.23.1927 (Address) 424 E. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Mount Olivet Sept 26 1927

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25842 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25842

CERTIFICATE OF DEATH.

REGISTERED NO. 51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 654 W. Fayette ST., 125 WARD)

2-FULL NAME Mary E Sands

(a) RESIDENCE NO. 654 W Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Sands

6 DATE OF BIRTH (month, day, and year) May 16, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Magness

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Rogers (Address) 654 W. Fayette St

15 Filed , 19 per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1927, to Sept 23, 1927, that I last saw her alive on Sept 23, 1927, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL Sept 26 1927

20 UNDERTAKER [illegible] ADDRESS 502 E North Ave

Cor.—12-9-25—A Co.—200 Bks.

E 25843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25843

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-31 Ward 128)

2-FULL NAME Frank J Dougan

(a) RESIDENCE NO. Not Known St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 35 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boatman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Roanoke (State or country) Va

PARENTS

10 NAME OF FATHER Boatman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Wm O'Donnell (Address) 1816 N Eutaw St

15 Filed 19 RFW Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Acute Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

Signed M. D.

(Coroner) 19 (Address) 1431 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Roanoke Va. Date of Burial 9/24 1927

20 UNDERTAKER J. A. Moran ADDRESS 300 E Baltimore

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25844

CERTIFICATE OF DEATH.

3 NE 25844

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 369 W Preston ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celester Powell

(a) RESIDENCE NO. 369 W Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Howard County Md

PARENTS

10 NAME OF FATHER John Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lizzie Stanton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Viola Powell

(Address) 369 W. Preston

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1927. to Sept. 22, 1927.. that I last saw her alive on Sept. 21, 1927. and that death occurred, on the date stated above, at 4-30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis acute Dont know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Mute, M. D.

, 19 (Address) 1029 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waisy Md.

DATE OF BURIAL 9/25 1927

20 UNDERTAKER Byrow & Wright

ADDRESS 1218 Mc Elderry St

TION is very important. See instructions on back of certificates.

H. HAMILTON JONES, M. D.

Registrar

Spec.—1-12-23—M&T—500 Blks.

E 25845 · HEALTH DEPARTMENT—CITY OF BALTIMORE · E 25845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 914 N Charles 11-24 (114)

CITY OF BALTIMORE: (No. ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Bingham Cooke

(a) RESIDENCE NO. 914 N Charles St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 88 yrs. 10 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, ~~Husband of~~ ~~(or Wife of)~~ Widow of Dr. Theodor Cooke Jr

6 DATE OF BIRTH (month, day, and year) Oct 24 1839

7 AGE: Years 88 | Months 10 | Days 30 | If LESS than 1 day, ___ hrs or ___ min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Wm Sheridan Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Conn.

12 MAIDEN NAME OF MOTHER: Jane Kelso

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Nancy B. Gibson

(Address) 914 N. Charles St

15 Filed ____, 19__ : ACH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1927, to Sept 23, 1927, that I last saw h alive on Sept 23, 1927, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) ___ yrs. ___ mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? At place of Death

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Theodor Cooke Jr M. D.

, 19 (Address) Hopkins Hosp. & 914 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. Cem.

DATE OF BURIAL: 9/26 1927

20 UNDERTAKER: Henry W. Jenkins' Sons Co

ADDRESS: Orchard & Calhoun

THIS IS VERY IMPORTANT

1927 CLARKSON JONES, M. D.

Spec.—12 9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25846

CERTIFICATE OF DEATH.

129 E 25846

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 4 (Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Dannie Fried

(a) RESIDENCE NO. 415 N. Wolfe St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 15 yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Fried

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 47 | Months | Days | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Russia

14 Informant: Jacob Fried

(Address): 415 N. Wolfe St.

15 Filed _____ 19___ _____ Registrar

C. BYRON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 23, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1927, to Sept 23, 1927, that I last saw h__ alive on Sept 23, 1927, and that death occurred, on the date stated above, at 11.20 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis hypertension

Chronic nephritis

CONTRIBUTORY (Secondary): Myocardial insuff. Asthma

(duration) 1 yrs. 10 mos. ___ ds.

(duration) ___ yrs. ___ mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of _____

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) Milton Sherry, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — Date of Burial: 7/25 19 27

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 Eutaw St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25847 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25847

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3712 Reisterstown Rd ST. 15-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Davison

(a) RESIDENCE NO. 3712 Reisterstown Road ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Davison

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE: Years 58 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Henry Horst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Abraham Davis (Address) 3712 Reisterstown Rd.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1928, to Sept 24, 1927, that I last saw h[illegible] alive on Sept 24, 1927, and that death occurred, on the date stated above, at 10:00 m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

Hypertension

(duration) 2 yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible], M. D.

Sept. 19 27 (Address) 1102 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Hebron

DATE OF BURIAL: 9/2 1927

20 UNDERTAKER: Jack Laurs

ADDRESS: 1139 Eutaw St

CHAMPION JONES, M. D.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25848

90 E 25848

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSP[illegible] St. 9-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hagan

(a) RESIDENCE NO. 1122 E. 36th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. ? 4, 1857

7 AGE — Years: 69 — Months: 10 — Days: 20 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Packer. do

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Clark & Jones

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Hagan

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Duncan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant

(Address) Records.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24/1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1927 to Sept. 24, 1927

that I last saw him alive on Sept. 24, 1927

and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic

Cirrhosis Liver

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) C. Stevens Berg, M. D.

....., 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: Sept 27 1927

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

very important. See instructions on back of certificates.

BALTIMORE CITY HOSPITALS
C. HARRISON JONES, M. D.
1927

Spec.—1-12-23—M&T—500 Blks.

E 25849

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25849

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W D 9 H ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Bentz

(a) RESIDENCE NO. Lansdowne Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occ 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Bentz

6 DATE OF BIRTH (month, day, and year) Jan 23, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	82	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Ice Co

9 BIRTHPLACE (city or town) (State or country) Maryland (Balto

PARENTS

10 NAME OF FATHER Paul Bentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Amelia Goetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Bentz (Address) Lansdowne Md

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1927

17 I HEREBY CERTIFY, That I attended deceased from 7/21, 1927, to 9/24/1927, that I last saw him alive on 9/24/1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uremia

Strangulated hernia

Coma

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Strangulated hernia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) S. C. Feldman, M. D.

, 19 (Address) W. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Sept 27 1927

20 UNDERTAKER Fulton Coh ADDRESS 3726 E. Monument

Spec.—1-12-23—M&T—500 Bks.

E 25850 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25850

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Wisniewski

(a) RESIDENCE NO. North Point Road Bello Co ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred X yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-17-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Benj. Wisniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosa Gattus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 MAR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 19 27, to Sept 24, 19 27, that I last saw h[illegible] alive on Sept 24, 19 27, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Teratoma sacrum

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Allen Blakeslee, M. D.

, 19 (Address) the Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Sept 27 19 27

20 UNDERTAKER Frank Brocklesby — ADDRESS 1906 Eutaw

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25851

CERTIFICATE OF DEATH

E 25851

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. Montreal Apartments St. Charles & 40th Ward 11th)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kate Hay West.

(a) RESIDENCE NO. Montreal Apartments St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph S. West.

6 DATE OF BIRTH (month, day, and year): May 27. 1852

7 AGE — Years: 75 Months: 3 Days: 26 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Jesse Hay

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Rosanna Linn

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant (Address): Joseph S. West Montreal Apts.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Sept. 23. 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12 1927 to Sept 23. 1927

that I last saw her alive on Sept 23. 1927

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis (primary)

Cerebral Arterio-Sclerosis (secondary)

about 2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

Incidental (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. F. Lockwood M. D.

19 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Sept 26 1927 | Date of Burial 19

20 UNDERTAKER: John O. Mitchell & Son | ADDRESS 1300 Eutaw Place

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25852 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S Dallas St. ST. 3-4 WARD)

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Wodka

(a) RESIDENCE NO. 711 S Dallas St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Wodka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Klimek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14

Informant Anna Wodka

(Address) 711 S Dallas St.

15

Filed ... 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1927, to Sept 24, 1927.

that I last saw h[illegible] alive on Sept 24, 1927.

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Sept 26 27 (Signed) William J. Rapanek M. D.

(Address) 801 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Sept 26 1927

20 UNDERTAKER ADDRESS

John N. Weber 1803 Bond

Spec.—1-12-23—M&T—500 Bks.

E 25853

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. U.S. Marine Hosp. ST.) 4 WARD)

2-FULL NAME Gutierrez, Feliciano

(a) RESIDENCE NO. 715 Chesapeake St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wh	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Carmen Gutierrez

6 DATE OF BIRTH (month, day, and year) 7/15/1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	26	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) S.S. Evelyn

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER Feliciano Gutierrez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Carmen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant U.S. Marine Hosp. Records
(Address)

15 Filed ....., 19 .....

T. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23/1927

17

I HEREBY CERTIFY, That I attended deceased from 8/29/1927, to 9/23/1927.

that I last saw h~~im~~ alive on 9/23/1927

and that death occurred, on the date stated above, at 8:10 p m.

The CAUSE OF DEATH* was as follows:

Fever, cause undetermined, Possibly Pulmonary Tuberculosis

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Acute Laryngitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No - Returned Marine

What test confirmed diagnosis?

(Signed) R. Upshur Thorton, M. D.

9/27, 1927 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Sept 26 1927
20 UNDERTAKER E. LeRoy Hoffler	ADDRESS 1555 North ave

Spec.—12-9-25—A Co.—200 Bks.

E 25854

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 25854

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 216-E-23rd St. 12-50 Ward)

2-FULL NAME Lillie Belle Holcomb

(a) RESIDENCE NO. 216-E-23rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edward Holcomb

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) York Co., Va.

(State or country)

PARENTS

10 NAME OF FATHER Pete Wright

11 BIRTHPLACE OF FATHER (city or town)

(State or country) York Co., Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) York Co., Va.

14 Informant Edward Holcomb.

(Address) 216 E. 23rd st.

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1927

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Sept 22, 1927,

that I last saw h... alive on Sept 22, 1927,

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Cardio Renal Disease

(duration) ...yrs. 7 mos. 22 ds.

CONTRIBUTORY

(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death

Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. A. Johnson, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. Date of Burial Sept 26. 27

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1725 Ashland Ave

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 25855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 25855

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Bruce ST. 16-22 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Gantt

(a) RESIDENCE No. 704 Bruce ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: John A. W. Gantt

6 DATE OF BIRTH (month, day, and year): Oct. 17. 1882

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
44	11	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer): Housekeeping
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Daniel Coates

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant (Address): John A. W. Gantt 704 Bruce St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1926 to Sept 22, 1927 that I last saw h[illegible] alive on Sept. 20, 1927 and that death occurred, on the date stated above, at 9. A. m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma ?

(duration) 1 yrs. 2 mos.? ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1071 Myrtle Ave

Did an operation precede death? Yes Date of

Was there an autopsy? No

What [illegible] confirmed diagnosis? Operation & Histology

(Signed) [illegible] M. D.

Sept 22, 1927 (Address) 1[illegible] Preston

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: Sept 25 1927

20 UNDERTAKER: Mrs. R. C. Elliott — ADDRESS: 1725 Madison Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 25856

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25856

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3737 Mondawmin Ave. WARD) 3-54

2-FULL NAME Harriet E. Burst

(a) RESIDENCE NO. (Usual place of abode) 3737 Mondawmin Ave. WARD

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank M. Burst

6 DATE OF BIRTH (month, day, and year) Oct 7 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	75	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER David Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Perine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frank M. Burst

(Address) 3737 Mondawmin Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-17, 1927, to 9-23, 1927, that I last saw h[illegible] alive on 9-23, 1927, and that death occurred, on the date stated above, at 2:00 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) Hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 6 days

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic

(Signed) Henry Nesbitt, M. D.

9-25. 1927 (Address) 3902 Greenland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Sept 26 1927
20 UNDERTAKER	ADDRESS
H. J. Deckelmann & Sons	Reg'd

TION is very important. See instructions on back of certificate.

C. HAMILTON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 25857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-081

E 25857

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Chestnut Hill ST. 4-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt Ogle

(a) RESIDENCE NO. 519 Chestnut Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Sarah V (Mett) Ogle

6 DATE OF BIRTH (month, day, and year) Apr 13, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk of Court retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Robt Ogle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Sarah E. Nicholson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Mrs Ethel Bucink 519 Chestnut Hill Ave

15 Filed Sept 24, 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1927

17

I HEREBY CERTIFY, That I attended deceased from Apr 8, 1927, to Sept 23, 1927, that I last saw h~~e~~r alive on Sept 23, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans
(Hemaplegia)

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H E Krantz, M. D.

(Address) 4025 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk Cemetery	Sept 26 1927
20 UNDERTAKER	ADDRESS
Wm J Dickson & Sons	Pa Ave

TION IS very important. See instructions on back

Spec.—1-12-23—M&T—500 Blks.

E 25858

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25858

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3822 Sequoia Ave ST. 5-62 WARD)

2-FULL NAME Maud Eudora Thomas

(a) RESIDENCE NO. 3822 Sequoia Ave ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 45 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Lewin Thomas

6 DATE OF BIRTH (month, day, and year) Feb. 1 1869

7 AGE Years 58 Months 7 Days 22 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Richard M. Cochrane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary E. Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cal Co. Md.

14 Informant Mr. Richard Thomas.

(Address) 3722 Woodland Ave.

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 4th, 1927, to Sept 23, 1927, that I last saw him alive on Sept 23, 1927, and that death occurred, on the date stated above, at 11.20 P m

The CAUSE OF DEATH* was as follows:

Generalized Arterio Sclerosis: Chronic Nephritis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial degeneration. Cerebral hemorrhage.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Hanover Pa.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Michel M. D.

Sept 27 1927 (Address) 790 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem.

DATE OF BURIAL Sept 26 1927

20 UNDERTAKER W. Tucker Sons

ADDRESS Hanover Pa

Spec. -7-17-26—A Co.—200 Bks.

E 25859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 25859

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 745 N. Kenwood Ave St.) (6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Schleicher

(a) RESIDENCE NO. 745 N. Kenwood Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S. if of foreign birth? 73 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: ~~HUSBAND of~~ late Louis Schleicher

6 DATE OF BIRTH (month, day, and year): Dec 22/48

7 AGE — Years: 78 Months: 10 Days: 24

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Jerscheid

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Ger.

14 Informant: Mrs. Aug Surecht

(Address): 745 N. Kenwood Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21/27 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 21 19 ..., to Sept 21 19 ...

that I last saw h[illegible] alive on Sept 21 19 ...

and that death occurred, on the date stated above, at 7:01 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. C. O'Donovan, M. D.

Sept 22 19 (Address) 1710 E 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: 9/25 19 27

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans St

Be plain and full, so that it may be properly classified. Name, surname of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 25860

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25860

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3912 Belair Road ST. 7th WARD)

2-FULL NAME Charles C Smith

(a) RESIDENCE NO. 3912 Belair Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary E Smith

6 DATE OF BIRTH (month, day, and year) Oct 13th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Londe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant ..... (Address) 3912 Belair Road

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-23 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-17 1925 to 9/23 1927.

that I last saw h alive on 9-23 1927,

and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Tabes Dorsalis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Gross signs

(Signed) David Myers, M. D.

9/23 1927 (Address) 14 W Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 26 1927
20 UNDERTAKER	ADDRESS
George Weems & Sons	1616 Monument

TION is very important. See instructions on back of certificates.

CHARLTON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25861

CERTIFICATE OF DEATH.

161-006

E 25861

1-PLACE OF DEATH

City of BALTIMORE: (No. 1135 Bolton St. 11-24 Ward)

2-FULL NAME Anna Belle Handy

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1135 Bolton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23, 1927

7 AGE — Years — Months 2 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER John Lunnie Handy

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Belle Reed

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant John Handy

(Address) 1135 Bolton St

15 Filed....., 19.....

Registrar

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1927, to Sept 24, 1927, that I last saw h[illegible] alive on Sept 24, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Congenital Birth

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

19 (Address) 2329 Georgia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary cem. Date of Burial Sept 30 27

20 UNDERTAKER Mrs. R.A. Elliott ADDRESS 1325 Ashland Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25862

CERTIFICATE OF DEATH

90 E 25862

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5504 Park Heights Ave St. 24 Ward 55)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. O'Connell

(a) RESIDENCE NO. 5504 Park Heights Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha E. O'Connell

6 DATE OF BIRTH (month, day, and year): Dec. 24-1874

7 AGE: Years 52 Months 8 Days 29 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Inspector in

(b) General nature of industry, business, or establishment in which employed (or employer): Can Company

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Thos. O'Connell

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Gallagher

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Ireland

14 Informant: Martha E. O'Connell (Address) 5504 Park Heights Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to Sept 22, 1927, that I last saw him alive on Sept 22, 1927, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Mitral Regurgitation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted —

if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles J. Mills, M. D.

19 (Address) 2242 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial 9/26 1927

20 UNDERTAKER: Chas J. Manuel & Son — ADDRESS 1101 Mt Royal Ave

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25863

CERTIFICATE OF DEATH

31

E 25863

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals 23-51 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mack

(a) RESIDENCE NO. 903 Plum Alley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Mack

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ....., 19.... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Sept. 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1927, to Sept. 21, 1927, that I last saw him alive on Sept. 21, 1927, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Bilateral far advanced Pulmonary tuberculosis with cavitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry C. Smith M. D.

9-21. 1927 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown

Date of Burial 9/25 1927

20 UNDERTAKER J. J. Talley Sons

ADDRESS 318 Fifth

IN DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25864

CERTIFICATE OF DEATH.

129 E 25864

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. So. Balt. Gen. Hosp. St. 2-32 Ward)

2-FULL NAME William Slagle

(a) RESIDENCE NO. 4 Weinder St. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliz Hamilton

6 DATE OF BIRTH (month, day, and year): - - 88

7 AGE: Years 39 | Months - | Days - | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Wm Slagle

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Short

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant (Address): Eliz Hamilton + Eutaw St.

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Sept. 23. 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 9 1927, to Sept. 23, 1927, that I last saw him alive on Sept. 23, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Renal Disease with Uremia and Internal hemorrhage

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) ____ yrs. 4? mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Battaglia, M. D.

, 19 (Address) So. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial 9/26 1927

20 UNDERTAKER: John J. Deluca & Sons ADDRESS 318 Eighth St

very important. See instructions on back of certificates.

CARLTON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25865

CERTIFICATE OF DEATH.

161-001

E 25865

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1133 N Milton St. 8-17 Ward)

2-FULL NAME Josephine Koppenberger

(a) RESIDENCE NO. 1133 N. Milton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 24/27

7 AGE	Years	Months	Days	IF LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General natnre of industry, business, or esiablishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md 9/25/27

(State or country)

PARENTS

10 NAME OF FATHER Leo J. Koppenberger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary H. Stoeckert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Green Co Pa

14 Informant Leo J Koppenberger

(Address) 1133 N. Milton

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primaturity — 8 mos gestation

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Carter, M. D. (Coroner)

(Address) 508 E Lanvale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the state....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial Sept. 26 1927

20 UNDERTAKER Henry Hauck Son ADDRESS 1301 E Eager St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

700-001

E 25866

CERTIFICATE OF DEATH

E 25866

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1232 E. Chase St. 10th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Guenther

(a) RESIDENCE NO. 1232 E Chase St. 10 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S. if of foreign birth 34 yrs. — mos. — da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Magdelena Guenther

6 DATE OF BIRTH (month, day, and year): October 1 1860

7 AGE — Years: 66 — Months: 11 — Days: 23 — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Brewer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (City or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. Magdelena Guenther

(Address) 1232 E. Chase St

15 Filed SEP 26 1927 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 24 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 19 27, to Sept 24 19 27.

that I last saw h— alive on Sept 24 19 27

and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency.

Contributory Bronchio-pneumonia (duration) ____ yrs. ____ mos. ____ ds.

(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of ____

Was there an autopsy? No.

What test confirmed diagnosis? ____

Sept. 27 19 27 (Signed) John A. Bohrer M. D.

(Address) 1339 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Sept. 27 1927

20 UNDERTAKER: Henry Stoeckle Son — ADDRESS: 601 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 25867

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25867

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1239 E Eager St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M. Russ

(a) RESIDENCE NO. 1239 E Eager St. 10 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Reginus Russ

6 DATE OF BIRTH (month, day and year) February 19 1836

7 AGE Years 91 Months 7 Days 5 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER John Stentaner

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Kunigunda Heubeltheis

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Wm. John Schmidt

(Address) 1239 E Eager St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Sept 24, 1927, that I last saw her alive on Sept 1, 1927 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Senility

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas J Coonan M. D.

Sept 24 1927 (Address) 1001 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — Date of Burial Sept 27 1927

20 UNDERTAKER Henry Stoecklein — ADDRESS 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

25868

E 25868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25863

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 229 N Poppleton St., 18 Ward)

2-FULL NAME Nattie C Bury

(a) RESIDENCE NO. 229 N Poppleton St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced: Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Bury

6 DATE OF BIRTH (month, day, and year): Oct 12 - 1866

7 AGE: Years 60. Months 11 Days 11 IF LESS than 1 day.....hrs. or.....min. 60.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Frank A Gruber

(Address) 312 S. Hanover Ave. Hamilton

15 Filed..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 23 1927

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Edema

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

Sept 25 1927 (Signed) G E Stadel M. D.

(Coroner)

(Address) 1438 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Date of Burial 9-26-1927

20 UNDERTAKER: H C Brauning Son - Schroeder

ADDRESS 31[illegible]

Cor. of certificate. very important. See instructions on back of

Spec.—1-12-23—M&T—500 Blks.

E 25869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 E 25869

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 760 Vine St., 4-16 WARD)

2-FULL NAME Elsworth Dorsey

(a) RESIDENCE NO. 760 Vine St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 26/94.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
33	32	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thos. E. Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Sarah Dorsey (Address) 760 Vine St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Sep. 21, 1927, to Sep. 23, 1927, that I last saw h alive on Sep. 23, 1927, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheeler M. D

Sep 27 1927 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Sept 26 1927

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill

TION IS very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25870 (Bentalou Hosp.)

CERTIFICATE OF DEATH

3 T 001

E 25870

1-PLACE OF DEATH Bet Park Hgts - Resistration Dist — REGISTERED NO.

City of BALTIMORE: (No. Strathmor Park Hospital St. 1274 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millie Viola George

(a) RESIDENCE NO. University Apts. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 66 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Alfred George

6 DATE OF BIRTH (month, day, and year) about 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
about	66	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Accomac Co.,

(State or country) Va.

PARENTS

10 NAME OF FATHER Jacob G. Senderling

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah G. Rogers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. G. Ladenfang (daughter)

(Address) University Apts.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Sept-23

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 .., to Sept 23, 19 ..,

that I last saw h.. alive on Sept 23, 19 ..,

and that death occurred, on the date stated above, at 1 1/2 m.

The CAUSE OF DEATH* was as follows:

Acute Coronary Thrombosis

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No By

What test confirmed diagnosis?

(Signed) ..., M. D.

..., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Cemetery	Sept-26-27
20 UNDERTAKER	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25871

CERTIFICATE OF DEATH.

3 E 25871

1-PLACE OF DEATH 202 N. Green St.

CITY OF BALTIMORE: (No. 202 ST., 4 WARD 25)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Luciano

(a) RESIDENCE NO. 202 N. Green St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Luciano

6 DATE OF BIRTH (month, day, and year) 2 | 12 | 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	33	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frisa Lanciano Italy

PARENTS

10 NAME OF FATHER Nicola Luciano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frisa Chieti Italy

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frisa Italy

14 Informant (Address) 202 Green St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1927

17

I HEREBY CERTIFY, That I attended deceased from July 25th, 1927, to Sept 24 1927, that I last saw him alive on Sept 23rd 1927, and that death occurred, on the date stated above, at 2:35 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis and Acute Nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy. Exam.

(Signed) G. B. Underwood, M. D.

9/24, 1927 (Address) 1901 Eutaw Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 9/26 1927

20 UNDERTAKER George & Ruth

ADDRESS 1735 Harford Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25872

CERTIFICATE OF DEATH.

90

E 25872

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Pronounced dead at St. Joseph Hospital St 1013 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Fleckenstein

(a) RESIDENCE NO. 1109 N. Eden St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2/1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Fleckenstein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Grossman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Catherine Fleckenstein

(Address) 1109 N. Eden St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25/ 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Weber, M. D. (Coroner)

9/25/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial 9/26 1927

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

Physician to fill out this certificate. Read carefully the instructions on back of certificate. Every question should be answered. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 25873 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25873

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 20 Caton Ave

CITY OF BALTIMORE: (No. 20 ST. 20-20 WARD) REGISTERED NO. 74-501

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances C. Lynch

(a) RESIDENCE NO. 20 Caton Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Lynch

6 DATE OF BIRTH (month, day, and year): March 17th 1866

7 AGE: Years 61 | Months 6 | Days 1 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Ramp Register

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER: Michael Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Laura Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Margaret Lynch

(Address): 20 Caton Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from October 1st, 1926, to Sept 1st, 1927, that I last saw him alive on August 30th, 1927, and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

1 hour.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) 7 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar S. Perkins, M. D.

, 19 (Address) 1 West Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral | DATE OF BURIAL: Sept 19 27

20 UNDERTAKER: John Stull | ADDRESS: 1200 W Lexington

IT IS very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 25874

NELLIE SCHREIVER

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. 117 E 25874

City of BALTIMORE: (No. 710 Gilmor St., 20-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Nellie Schreiber

(a) RESIDENCE, NO. 427 Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 5 mos. 16 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W.

5 (Single, Married, Widowed, or Divorced, (write the word) Married Female

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/9/1875

7 AGE Years 52 Months 5 Days 16 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Lewis Schreiber

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md

12 MAIDEN NAME OF MOTHER Loretta Vogel

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant (Address) Hospital Records

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 1.25.27

17 I HEREBY CERTIFY, That I attended deceased from 9.12.27, 19....., to 9.25.27, 19.....

that I last saw h.. alive on 9.25.27, 19.....

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

A. Appendicitis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 17 hrs

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of 9.13.27

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~, CREMATION ~~OR REMOVAL~~ — Date of Burial

Loudon Park — 28 Sept 1927

20 UNDERTAKER [illegible] — ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. Each statement is of very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25875

CERTIFICATE OF DEATH

E 25875

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No. Green & Lombard Sts., 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Lacy

(a) RESIDENCE NO. 17 N. Civic St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred about 5 days yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 8-57

7 AGE: Years 70 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer [illegible]

9 BIRTHPLACE (city or town)

(State or country) St. Louis, [illegible]

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Record

(Address)

15 Filed ..., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 9-24-27

17 I HEREBY CERTIFY, That I attended deceased from 9-10, 19 27, to 9-24, 19 27, that I last saw h[illegible] alive on 9-24, 19 27, and that death occurred, on the data stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Arrhythmia

Nephritis (duration) yrs. mos. ds.

CONTRIBUTORY Cerebral Embolism

(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Lasell, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — Date of Burial Sept 27 1927

20 UNDERTAKER John J. Cowan & Son. — ADDRESS 901 N. Collins St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 25876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25876

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 13-59 Ward)

2-FULL NAME Joseph Askin

(a) RESIDENCE NO. 2309 Orem Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Askin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Askin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Katzen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eastern

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 19 27

17 I HEREBY CERTIFY, That I attended deceased from 8/29, 19 27, to 9/25, 19 27, that I last saw him alive on 9/25, 19 27, and that death occurred, on the date stated above, at 4 05 P m.

The CAUSE OF DEATH* was as follows:

Hypertension, arteriosclerosis

Chronic nephritis, Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insuff. Coronary embolism

(duration) yrs. mos. 2d ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Ex.

(Signed) Mulkey Sherry, M. D.

9/25 1927 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — Date of Burial 9/26 19 27

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 Eastern Av

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 25877

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25877

CERTIFICATE OF DEATH

1-001

1-PLACE OF DEATH

REGISTERED NO. 18-29

City of BALTIMORE: (No. Baltimore City Hospitals St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Fosque

(a) RESIDENCE NO. 671 Boyd st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE Years 20 Months 23 Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer -

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Fosque

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed SEP 26 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 23, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15 27, 19, to Sept. 23 27, 19, that I last saw him alive on Sept. 23 27, 19, and that death occurred, on the date stated above, at 12.45 A. M. m.

The CAUSE OF DEATH* was as follows: Malaria fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Henry C. Smith M. D.

9-23-19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — Date of Burial Sept 26 1927

20 UNDERTAKER C. W. Brown & Son — ADDRESS Woodbury

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25878

CERTIFICATE OF DEATH.

188-003

REGISTERED NO. E 25878

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. General Hosp. St. 3-4 Ward)

2-FULL NAME Gilbert Evans

(a) RESIDENCE NO. 744 S. Bond St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: [illegible]

4 Color or Race: [illegible]

5 Single, Married, Widowed, or Divorced, (write the word): [illegible]

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) About 1865

7 AGE: Years 62 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) [illegible]

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant [illegible]

(Address) [illegible]

15 Filed 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

accident (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Auto accident

(duration) yrs. mos. ds.

(Signed) J. J. Kenney M. D.
(Coroner)

19 27 (Address) 257 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Date of Burial Sept 27 1927

20 UNDERTAKER John E Henderson ADDRESS 1502 E. Monument

very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 25879

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25879 ✓

31

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie May Hazelton

(a) RESIDENCE NO. 1415 Myrtle ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Hazelton

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Eli Preston

11 BIRTHPLACE OF FATHER (City or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Martha Witherspoon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1927, to Sept. 23, 1927, that I last saw her alive on Sept. 23, 1927, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Interlobar Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Smith, M. D.

9-24, 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial 9/27/19 27

20 UNDERTAKER Mrs. Geo. E. Holland — ADDRESS 16 N. Druid Hill Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 25880

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25880

CERTIFICATE OF DEATH.

14

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 623 W. Biddle St. 7-24 Ward)

2-FULL NAME Hatty Dais

(a) RESIDENCE NO. 623 W. Biddle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Dais

6 DATE OF BIRTH (month, day, and year): 1497

7 AGE: Years: about 30 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Wm Smith

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Carter

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Jno Carter

(Address) 2200 Biddle

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 23 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Exhaustion of Age

(duration) .....yrs. .....mos. .....ds.

(Signed) J. J. Hennessy M. D.

(Coroner)

1927 (Address) 25 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs., ...mos., ...ds. In the State.....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Date of Burial Sept 26 1927

20 UNDERTAKER: Daniel Easton ADDRESS 916 Eutaw

Registrar

Fill in all items, if none, write none. Be sure statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25881

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25881 ✓

CERTIFICATE OF DEATH.

90 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen. Hospital (STREET OR AVENUE) (WARD)

REGISTERED NO. 18529

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ruth Panos

(a) RESIDENCE NO. 1119 Hollins ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE — Years: 66 — Months — Days — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Greece

PARENTS

10 NAME OF FATHER: Gus Konstadine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Ruth Fragis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant: George Panos (Address) 1119 Hollins

15 Filed . 19 Registrar

SEP 26 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to Sept 25, 1927, that I last saw h[illegible] alive on Sept 25, 1927, and that death occurred, on the date stated above, at 24. m

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Mitral Insufficiency
Aortic Insufficiency

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No Chief. Exam.

What test confirmed diagnosis?

(Signed) Louis T. Lacy, M. D.

9/25, 27 (Address) W. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: 9/27 1927

20 UNDERTAKER: Harnett Easton ADDRESS 916 Cathedral

TION IS very important. See instructions on back

Spec.–7-17-26—A Co.—200 Bks.

E 25882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 185 ✓ E 25882

1-PLACE OF DEATH Hospital for Women of Md. REGISTERED NO. 14-20

City of BALTIMORE: (No. Baltimore St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Florence G. Hipsley

(a) RESIDENCE NO. Glyndon Md - St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. — mos. — ds. 4 (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of Charles Hipsley

6 DATE OF BIRTH (month, day, and year) August 2/1859

7 AGE: Years 68 Months 1 Days 3 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Co - Md.

PARENTS

10 NAME OF FATHER John Gent -

11 BIRTHPLACE OF FATHER (City or town)

(State or country) maryland -

12 MAIDEN NAME OF MOTHER Anna E. Hurt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Nellie B. Gore - (niece)

(Address) Reisterstown Md -

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24th - 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1927, to Sept. 24, 1927, that I last saw h.. alive on Sept. 24, 1927, and that death occurred, on the date stated above, at 7, 15 a. m.

The CAUSE OF DEATH* was as follows:

Fracture of neck of right femur. Accidentally fell over a step while leaving a dentist's office. (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocardial failure (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Sept 22, 1927

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Krouk, M. D.

. 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Druid Ridge Cemetery — Date of Burial 9-27-1927

20 UNDERTAKER H. T. Ecker ADDRESS Reisterstown Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 25883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-002 E 25883

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 3423 Mt. Pleasant ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank W. Reynolds.

(a) RESIDENCE NO. 3423 Mt Pleasant ave St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 20th 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Frank T. Reynolds

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Forsythe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md

14 Informant Frank T. Reynolds

(Address) 3423 Mt Pleasant ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1927, to Sept 26, 1927, that I last saw him alive on Sept 25, 1927, and that death occurred, on the date stated above, at 8 30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace M Sutton M. D.

9/26 1927 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Oak Lawn Cemetery — Sept. 27 1927

20 UNDERTAKER — ADDRESS

Lilly & Zeller — 703 W. Lafayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

E 25884 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 E. Lafayette Ave ST.) 8-27 (WARD) 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalena Brandt

(a) RESIDENCE NO. 1608 E. Lafayette Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George P. Brandt

6 DATE OF BIRTH (month, day, and year) Aug. 22. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Corn) 137

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Stengle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ??

14 Informant Mrs. Mary Brandt (Address) 1608 Lafayette Ave.

15 Filed ..... 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23 1927

17

I HEREBY CERTIFY, That I attended deceased from 1926 to Sept. 23 1927.

that I last saw h alive on Sept. 23 1927.

and that death occurred, on the date stated above, at 10.20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio-sclerosis

Chronic Int. Nephritis

Hypostatic

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. J. Marx M. D.

9-26-1927 (Address) 176 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuels Cem.	Sept 27 1927

20 UNDERTAKER Louis Heeman ADDRESS 32 Broadway

TION is very important. See instructions on back of certificate.

SEP 26 1927 F. A. JONES, M. D.

Spec.–7-17-26—A Co—200 Bks.

E 25885

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25885

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1237 E Lanvale St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Hoeck

(a) RESIDENCE NO. 1237 E Lanvale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 9 mos. 8 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of John H. Hoeck

6 DATE OF BIRTH (month, day, and year): Dec. 17 1852

7 AGE — Years: 74 — Months: 9 — Days: 8 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Henry Engel

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Catherine Ebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Marie F. Denny

(Address) 1237 E Lanvale St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M.

SEP 26 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 25th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 22 19 27 to Sept 25 19 27

that I last saw h[illegible] alive on Sept 25 19 27

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (General)

Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clara Jones M. D.

1927 (Address) 4 W Hoyt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemy — Date of Burial: Sept 28 19 27

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 201 E Eager St.

CERTIFICATES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co—200 Bks.

E 25886 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 25886**

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St 10-14 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Mullen

(a) RESIDENCE NO. Preston & Valley St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 50 yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Mullen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St

15 Filed_____, 19____ _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24th 1927

17

I HEREBY CERTIFY, That I attended deceased from No record, 19____, to ____, 19____,

that I last saw h__ alive on ____, 1927, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

Unknown (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY _____
(Secondary)

_____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Sept 26 1927 (Signed) F. A. Warner, M. D.

(Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial Sept 27 1927

20 UNDERTAKER Rita Windfield ADDRESS 914 Greenmt Ave

Of DEATH in plain terms, so that it may be properly classified. Certificates very important. See instructions on back of certificate.

C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

Klevlein

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25887

CERTIFICATE OF DEATH

90 E 25887

REGISTERED NO.

4-26

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [redacted] John Doelum

(a) RESIDENCE NO. 123 N. Fremont Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE — Years: 70 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Street cleaner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: City

9 BIRTHPLACE (city or town)

(State or country): Ireland

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland

14 Informant (Address): [redacted] CITY HOSPITALS

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/24/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1922 to Sept. 24, 1927 that I last saw h[illegible] alive on Sept. 24, 1927 and that death occurred, on the date stated above, at 4:00 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic
Arteriosclerosis
Hypertension

(duration) ..... yrs. 3 mos ..... da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Symptoms & Sym

(Signed) C. Wilmer Brown M. D.

19 (Address) CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem. — Date of Burial: Sept 27 1927

20 UNDERTAKER: John J. Cowan & Son. — ADDRESS: 901 Hollins St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

James P. Gilmore

E 25888 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25888

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2525 W Fairmount St. 70-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James P Gilmore

(a) RESIDENCE No. 2525 W Fairmount Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catharine Gilmore

6 DATE OF BIRTH (month, day, and year): Sept 16 1864

7 AGE: Years 53 Months ... Days 9 If LESS than 1 day, hrs. or min. ...

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: Mount Calvary

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Catharine Gilmore wife
(Address) 2525 W Fairmount Ave

15 Filed Sept 28 19 27 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1927

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1927, to Sept 25, 1927, that I last saw him alive on Sept 25, 1927, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Wallis A Cox, M. D.

9/26, 1927 (Address) 57 E Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer. DATE OF BURIAL 9-28-1927

20 UNDERTAKER: H. C. Blamminger Sons ADDRESS 517 N Schroeder St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

E 25889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25889

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 W. Hoffman St., 17-24 WARD)

2-FULL NAME Georgeanna Limberry

(a) RESIDENCE NO. 547 W. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Smith

6 DATE OF BIRTH (month, day, and year) Oct 12 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer) Private Cook

(c) Name of employer Miss Mary Easton

9 BIRTHPLACE (city or town) (State or country) Royal Oak Md

PARENTS

10 NAME OF FATHER Lloyd Limberry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Royal Oak Md

12 MAIDEN NAME OF MOTHER Hester Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frank Smith

(Address) 1108 McCulloh St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 14th, 1927, to Sept 23, 1927, that I last saw her alive on Sept 20th, 1927, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) — yrs 3 mos 17 ds

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) — yrs 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Examination

(Signed) Edward Eastlack M. D.

Sept 24 1927 (Address) 1339 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md — DATE OF BURIAL Oct 6 1927

20 UNDERTAKER Emmert Hennessy — ADDRESS N Bdlet

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 25890

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25890

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: St. Agnes Hospital Ward

2-FULL NAME Mary Lo. Bize Rudel.

(a) RESIDENCE NO. Catonsville Md. St. Ward

(Usual place of abode)

Length of residence in city or town yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 5th 1869

7 AGE: Years 57 Months 9 Days 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sales Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Catonsville Dist. Co.

(c) Name of employer: Catonsville Md.

9 BIRTHPLACE (city or town) Fredericksburg (State or country) Va.

10 NAME OF FATHER John Rudel

11 BIRTHPLACE OF FATHER (city or town) Fredericksburg (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Goff

13 BIRTHPLACE OF MOTHER (city or town) Fredericksburg (State or country) Va.

14 Informant Mary L. Rudel

(Address) Catonsville Md.

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7th, 1927, to Sept 25th, 1927

that I last saw h..... alive on , 19....,

and that death occurred, on the date stated above, at 10-40 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung - Primary — with metastasis to Bones.

Terminal Pulmonary Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? yes. Date of

Was there an autopsy? To be performed at Johns Hopkins Hosp.

What test confirmed diagnosis? Clinical & Surgical

(Signed) A. J. Knapp, M. D.

9-25, 1927. (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sterling, Illinois Date of Burial: Sept 26 1927

20 UNDERTAKER: H. B. Wiesent ADDRESS: 1501 W. Baltimore St

PARENTS

Very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

E 25891 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25891

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Gough ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Kane

(a) RESIDENCE NO. 2211 Gough ST., / WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos B Kane

6 DATE OF BIRTH (month, day, and year): Jan 7 - 1856

7 AGE: Years 71 | Months 10 | Days 17 | If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cork Ireland

PARENTS

10 NAME OF FATHER: Patrick Liffly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Kath Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Kane (Address) 2211 Gough St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-24-1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1927, to Sept 24, 1927, that I last saw h[illegible] alive on Sept 24, 1927, and that death occurred, on the date stated above, at 4.10 p m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease (duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Wm. Miller, M. D.

9-27, 1927 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Bethel Balto

DATE OF BURIAL: 9/27 1927

20 UNDERTAKER: J. A. Horan

ADDRESS 300 E Baltx

TION is very important. See instructions on back of certificates.

[illegible] C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 25892

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25892

CERTIFICATE OF DEATH.

10-002

23-31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Wilkens

(a) RESIDENCE No. 125 W Cross St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 8. 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	2	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Wilkens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Sadie Crowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Frank Wilkens

(Address) 125 W. Cross St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1927, to Sept 25, 1927, that I last saw her alive on Sept 25, 1927 and that death occurred, on the date stated above, at 6 40/a m.

The CAUSE OF DEATH* was as follows:

Pharyngeal & Laryngeal Diphtheria

(duration) yrs. mos. 1+ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated 9/24/27 (Date of)

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos. Cult

(Signed) Myron G. Tull M. D.

9/26 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Sept 28 1927
20 UNDERTAKER	ADDRESS
Jas Joesdens & Son	217 S. Bro...

TION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 25893

CERTIFICATE OF DEATH.

113 E 25893

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 923 N Chapel St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Handler

(a) RESIDENCE NO. 923 N Chapel St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1/27

7 AGE — Years: — Months: 4 — Days: 25 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt

(State or country)

PARENTS

10 NAME OF FATHER Charles Handler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balt

12 MAIDEN NAME OF MOTHER Jeni Satt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt

14 Informant Charles Handler

(Address) 923 N Chapel St

15 Filed ....., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1927, to Sept 26, 1927, that I last saw h.. alive on Sept 26, 1927, and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Gyaucch M. D.

(Address) 501 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Redeemer — Date of Burial Sept 27 1927

20 UNDERTAKER Frank Crockson — ADDRESS 1906 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25894

CERTIFICATE OF DEATH.

E 25894

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16½ Pine ST., 4-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Shepherd

(a) RESIDENCE NO. 16½ Pine ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 24 1927

7 AGE Years Months Days If LESS than 1 day, 2 hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 16½ Pine St Balt md

PARENTS

10 NAME OF FATHER Illegitimate

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER Mary Shepherd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1927

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 ..., to ....., 19 ..., that I last saw h... alive on ....., 19 ..., and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ino. D. Wooldridge M. D.

(Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: SEP 26 1927 19

20 UNDERTAKER: Commissioner of Health. — ADDRESS

C. HAMPSON JONES, M. D. Registrar

1927 1936

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25895

31 E 25895

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St., 354 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chester (Charles) Brown

(a) RESIDENCE NO. 218 S. Dallas st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Ned Brown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lizzie Nelson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed , 19

Registrar

1737

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September 22, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 19 27, to Sept. 22, 19 27,

that I last saw him alive on Sept. 22, 19 27,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) Henry C. Smith M. D.

9-22 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Commissioner Health.

Per. Wm. R. WOODALL

SEP 26 1927

UNIVERSITY OF MARYLAND

SEP 26 1927 C. HA[illegible]

If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25896

38

E 25896

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital 3-1 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fritz wilkins

(a) RESIDENCE NO. 6 5th S Broad St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years: 53. Months: Days: IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER Frederick wilkins

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) UNIVERSITY OF MARYLAND

15 Filed 19 Registrar

17:38 RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 13 19 27 to Sept 23, 19 27

that I last saw h alive on Sept 23, 19 27

and that death occurred, on the date stated above, at 9:10 m.

The CAUSE OF DEATH* was as follows:

Luetic Aortitis Myocarditis Arteriosclerosis and Mesaortic Aneurism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? yes Date of 9-22-27

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner of Health. SEP 26 1927

WM. R. WOODALL

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

25897.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 25897

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOS[illegible] St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Small

(a) RESIDENCE NO. 205 N. Poplar St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	36(?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cannery worker

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) Fredericksburg

(State or country) Va.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) ..... (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) ?

14 Informant ..... (Address) Records.

15 Filed ..... 19 ..... Registrar

26 1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927 to Sept 23, 1927

that I last saw her alive on Sept 23, 1927

and that death occurred, on the date stated above, at 2:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic and acute.

Myocarditis multiple

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? General ? Sub

(Signed) C. Hilliard Burgd, M. D.

. 19 (Address) BALTIMORE CITY HOS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	Date of Burial
Mt. Zion Cemetery	Sept. 26, 1927

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25898

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mary Dietz

(a) RESIDENCE NO. Catonsville Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12 1856

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
70	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Laurence A Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss C. Dietz

(Address) Maiden aloin Box. Catonsville

15 Filed 12 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1927

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1927, to Sept 24 1927, that I last saw h[illegible] alive on Sept 23, 1927, and that death occurred, on the date stated above, at 4:30 a m

The CAUSE OF DEATH* was as follows:

Chronic endocarditis.
Uremia
Cerebral embolism left front
Right hemiplegia

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Septic

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. F. Kelly M. D.

(Address) 110 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Daughters of the Eucharist Chapel-Maiden Choice Lane

DATE OF BURIAL Sept 27 1927

UNDERTAKER J. J. Linton & Son

ADDRESS Catonsville. Md.

IONS is very important See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25899

100 E 25899

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 1524 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Reinhardt

(a) RESIDENCE NO. 1811 N. Bulton Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 9 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ✓ [illegible] 1868

7 AGE: Years 58 Months 9 Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dallas.

(State or country) Md.

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ? [illegible]

12 MAIDEN NAME OF MOTHER ? [illegible]

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) ? [illegible]

14 Informant [illegible] CITY HOSPITALS

(Address) Reisterstown.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20/1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1920 to Sept. 20, 1927, that I last saw her alive on Sept. 20, 1927 and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

arthritis (duration) 8 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Gross & Sect.

(Signed) C. Hampson Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Sept 22 1927

20 UNDERTAKER: H. J. Tucker & Sons ADDRESS Mt Washington

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25900

CERTIFICATE OF DEATH.

E 25900

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. 100 N. Calhoun ST. 70-7 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustave Trautwein

(a) RESIDENCE NO. 19 Gen. Lyman Pl. Baltimore & Payson ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): February, 17th. 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Fritz Otto Trautwein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lucia Meier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Records German Aged Home Baltimore and Payson St.

15 Filed , 19 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/26/27 19

17 I HEREBY CERTIFY, That I attended deceased from 9/19/27, 19 , to 9/26/27, 19 ,

that I last saw h... alive on 9/26/27, 19 ,

and that death occurred, on the date stated above, at 9¼ P.M. m.

The CAUSE OF DEATH* was as follows:

Fractured left femur

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Clinical Signs

(Signed) ... M. D.

9/26, 27 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: Sept. 28 27

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 W Balto

CAUSE OF DEATH should be stated in plain English. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25901

CERTIFICATE OF DEATH.

E 25901

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) City Hospital St. 26-37 Ward)

2-FULL NAME Gresbury F. Hackett

(a) RESIDENCE NO. Hise Ave Baltimore Co Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elanora Hackett

6 DATE OF BIRTH (month, day, and year): Nov. 30 1865

7 AGE — Years: 61 — Months: 10 — Days: 24 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John F. Hackett

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Kezar Oliver

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant: Elanora Hackett

(Address): Hise Ave.

15 Filed ..... 19 ..... Registrar

C. CHAMPION JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc.

Multiple Injuries.

(duration) ..... yrs. ..... mos. 6 hrs.

CONTRIBUTORY (Secondary) Shock.

(duration) ..... yrs. ..... mos. ..... ds.

Signed) Gt. Champion Jones M. D.

(Coroner)

9/27 (Address) 143 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Sept. 27 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1710 Fleet St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25902

CERTIFICATE OF DEATH.

90 E 25902

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Falls Road St. 13-51 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie A. Bell

(a) RESIDENCE No. 1005 Falls Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Bell

6 DATE OF BIRTH (month, day, and year) Dec. 24-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	79	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David Forts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Priscella Gent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William E. Bell

(Address) 1005 Falls Road

15 Filed ....., 19 ..... Registrar

RPW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1927, to Sept 24, 1927,

that I last saw h[illegible] alive on Sept 24, 1927,

and that death occurred, on the date stated above, at 12-20 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Mitral Regurgitation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Endocarditis

Arteriosclerosis (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [signature], M. D.

, 19 (Address) 1005 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sater's Baptist Cem.	Sept 27 1927
20 UNDERTAKER Horace F. Burgee	ADDRESS 36 Hall Rd

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25903

CERTIFICATE OF DEATH.

90 E 25903

Registered No.

1-PLACE OF DEATH

City of BALTIMORE (No. 609 N Linden St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Lubka or Braun

(a) Residence No. 609 N Linden St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-Sex: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 3 1866

7-AGE 61 yrs. 6 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Peter Zirr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Australia

12-MAIDEN NAME OF MOTHER, Anna Zirdler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Australia

14- (Informant) Mary Braun

(Address) 609 N Linden St

15- Filed 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 25 27

17- I HEREBY CERTIFY, That I attended deceased from April 1927 to Sept. 25 1927

that I last saw h[illegible] alive on Sept. 25 1927

and that death occurred, on the date stated above, at 545 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis Endocarditis

Chronic Passive Congestion of

All Viscera

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Polsenny M.D.

19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: Sept 29 19 27

20-UNDERTAKER: John C Miller ADDRESS 2435 E Oliver

Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Mulb 5242
Park Heights Ave
5-001.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25904

CERTIFICATE OF DEATH.

E 25904

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Garrison Blvd & Denison ST., 47 WARD) 67

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie T. Tregor

(a) RESIDENCE NO. Garrison Blvd + Denison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Marcus Tregor

6 DATE OF BIRTH (month, day, and year) Feb 22 1884

7 AGE: Years 83 Months 7 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Julius Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry A. Tregor

(Address) Denison + Garrison Blvd

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1927, to Sept 25, 1927, that I last saw h alive on Sept 25 1927, and that death occurred, on the date stated above, at 3:40 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edgar Mills, M. D.

, 19 (Address) 5242 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Sept 27 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 E. North

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25905

CERTIFICATE OF DEATH

×54 E 25905

1-PLACE OF DEATH Balto City Hospl

City of BALTIMORE: (No. Balto Md St. N-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Harry Keeles Timms Station Md.

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 1876

7 AGE: Years 51 (50) Months 10 Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer (O.D.)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospl

(Address) Balto Md

15 Filed..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

9-25-27

17

I HEREBY CERTIFY, That I attended deceased from 9-22-, 1927, to 9-25-, 1927, that I last saw him alive on 9-25-, 1927 and that death occurred, on the date stated above, at 5.25 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Pellagra, Acute + Chronic Colitis

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry L. Friedman M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: Sept 28 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Hoffman

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 25906

E 25906

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Thorington

(a) RESIDENCE NO. 5 McKay's Court St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James A Thorington

6 DATE OF BIRTH (month, day, and year): May 9, 1849

7 AGE: Years 80 Months 4 Days 7

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Mrs Belle Rayner

(Address) 5008 McKay Court

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1927 to Sept 26, 1927

that I last saw h alive on Sept 26, 1927

and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Abscess pancreas and

Senile Gangrene Right Foot

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sept

(Signed) H. A. Peel, M. D.

19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: Sept 28 1927

20 UNDERTAKER: J M Cook — ADDRESS: 502 E North Ave

SEP 27 1927 C HARRY JONES M.D.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25907

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

16-31

E 25907

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1040 Edmondson Ave. St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer Duvall Stevens.

(Residence in Baltimore: No. 1040 Edmondson Ave. St.: 0 yrs., 0 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, August 19, 1887. (Month) (Day) (Year)

7-AGE, 40 yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Groceries

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Robert L. Stevens.

11-BIRTHPLACE OF FATHER (State or Country), Mass.

12-MAIDEN NAME OF MOTHER: Agnes Johnston

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin Nagle Stevens

(Address) 1040 Edmondson Ave.

15-

Filed ..... 191.....

Registrar.

1927 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 26, 1927. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 7 1927, to September 26 1927, that I saw him alive on September 26 1927, and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Tuberculosis, pulmonary chronic (Duration) 10 yrs. ? mos. ? ds.

(Signed) John L. Stanbury M. D.

Sept 26 1927 (Address) 1037 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge DATE OF BURIAL: Oct. 28 1927

20-UNDERTAKER: Aisquith & Little ADDRESS 2758 Edmondson Ave

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25908

CERTIFICATE OF DEATH.

E 25908
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 819 N. Charles St., 11-15 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clyde Craddock

(a) RESIDENCE NO. Same' ales. Sutton Va. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 29 1896

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
31	11	11	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman.
(b) General nature of Industry, business, or establishment in which employed (or employer) Coal Co.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER James
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.
12 MAIDEN NAME OF MOTHER Eliz Pedigo
13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant R. B. Craddock
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
Sudden (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY
(Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

6/27 (Signed) H. Feldman M. D.
(Coroner)
, 1926 (Address) 1054 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Roanoke Va Date of Burial 6/27 1926

20 UNDERTAKER R. S. Little ADDRESS 2100 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 25909

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25909

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 89

City of BALTIMORE: (No. 208-E-20th-St. St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John William Scaffe

(a) RESIDENCE NO. 208-E-20th-St. St. 12 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33yrs. ? mos. ? ds. How long in U. S. if of foreign birth 57 yrs. 7 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Hebb Scaffe

6 DATE OF BIRTH (month, day, and year) January-29-1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	57	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturers Agent.

(b) General nature of industry, business, or establishment in which employed (or employer) Various Lines.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Sumter,

(State or country) South Carolina.

PARENTS

10 NAME OF FATHER Thomas C.Scaffe

11 BIRTHPLACE OF FATHER (City or town) Sumter,

(State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Martha Jane Shore

13 BIRTHPLACE OF MOTHER (city or town) Winstn-Salem

(State or country) North Carolina.

14 Informant Mrs. Emily J.Scaffe, (wife)

(Address) 208-E-20th-St., City.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Sept. 25

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Abscess Peritoneum

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	Sept-28- 19
20 UNDERTAKER	ADDRESS

SEP 27 1927 HEALTH COMMISSIONER M. D.

STEWART & BROWN COMPANY

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 25910

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25910

CERTIFICATE OF DEATH

129

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1700 Bolton-St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Wright Mifflin

(a) RESIDENCE NO. 1700 Bolton-St. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 81 yrs 5 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of SINGLE.

6 DATE OF BIRTH (month, day, and year) March-27-1846

7 AGE	Years	Months	Days	IF LESS than 1 day ___ hrs. or ___ min.
	81	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Wrightsville,

(State or country) Lancaster Co., Penna.

PARENTS

10 NAME OF FATHER Samuel Wright Mifflin

11 BIRTHPLACE OF FATHER (City or town) Columbia

(State or country) Lancaster Co.,Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Martin

13 BIRTHPLACE OF MOTHER (city or town) Muncie

(State or country) Northumberland Co.,Pa

14 Informant Geo. Brown Mifflin, (brother)

(Address) 1700 Bolton St.,City.

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 Sept. 25th.

17 I HEREBY CERTIFY, That I attended deceased from Sept 16 1927 to Sept 25 1927 that I last saw h___ alive on Sept 25 1927 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis and Bronchial Complications

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) Edward C. Pind M. D.

9-25 1927 (Address) 1705 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbia, Lancaster Co., Pa. Date of Burial Sept-28-27

20 UNDERTAKER STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 1100 W. NORTH AVE.

OF DEATH in plain terms, so that it may be properly classified. Exact very important. See instructions on back of certificates.

of OCCUPATION

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~Hall Kelly Hall~~

E 25911 CERTIFICATE OF DEATH. 1927

E 25911
REGISTERED NO.

1-PLACE OF DEATH 1418 Eutaw Place

CITY OF BALTIMORE: (No. Bacto. Hd. ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bessie H. Summers

(a) RESIDENCE NO. 11 East Lane ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. Summers M. D.

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ingleside near Winston-Salem, N. C.

PARENTS

10 NAME OF FATHER Willis E. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Sallie C. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Oscar D. Green
(Address) 2038 Park Ave.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927, to Sept. 26, 1927, that I last saw her alive on Sept 26, 1927, and that death occurred, on the date stated above, at 8:45 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophic cirrhosis of the liver.

about 2 months.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cause.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Thomas Neill Jr., M. D.

(Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winston Salem N.C. DATE OF BURIAL Oct. 27 1927

20 UNDERTAKER John O. Mitchell Sons ADDRESS 1900 Eutaw Place

THIS CERTIFICATE MUST be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25912

CERTIFICATE OF DEATH.

74-001

E 25912

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1039 Brantley St. 16-7th Ward)

2-FULL NAME Chas L. Kennan

(a) RESIDENCE NO. 1029 Brantley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 4 mos. 29 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29 1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer C. Lawrence Kennard

9 BIRTHPLACE (city or town)

(State or country) Balt Md

PARENTS

10 NAME OF FATHER Joseph S Kennan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balt Md

12 MAIDEN NAME OF MOTHER Annie L Kent

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt Md

14 Informant Annie L Kennan

(Address) 1027 Hunter St

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) H E Slade M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lot of Kennard — Date of Burial Sept 28 1927

20 UNDERTAKER C. Lawson Kennard — ADDRESS 723 N Eutaw St

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25913

CERTIFICATE OF DEATH.

90 ✓

E 25913 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1044 Vine St. 18th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arlbrn ~~William~~ Cole

(a) RESIDENCE NO. 1044 Vine St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Cold	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Daisy Cole

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
about 40				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie Nelson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Daisy Cole

(Address) 1041 Vine St

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23rd 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained ~~by~~ ~~inquest~~ autopsy, and ~~inquiry~~ ~~hereto~~ attached, and ~~from~~ ~~my~~ ~~personal~~ ~~knowledge~~ find that said deceased came to ~~his~~ death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.

(Coroner)

Sept 25th 1927 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem Date of Burial Sept 28th 1927

20 UNDERTAKER A. Jones ADDRESS 111 S. Gilmor St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 25914

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25914

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals St. 26-25 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ereber Shane

(a) RESIDENCE NO. 317 S Paca St. Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary F. Shane

6 DATE OF BIRTH (month, day, and year): Nov. 9 – 1857

7 AGE: Years 69 70 | Months 10 | Days 23

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Lanbgord Shane

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Hannella Lanbgord

13 BIRTHPLACE OF MOTHER (city or town): Pennsylvania

(State or country)

14 Informant: Mrs. Mary F. Shane

(Address) Fenbrooke Md

15 Filed.....19.....

Registrar

Per.....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1927 to Sept 26, 1927

that I last saw him alive on Sept 26, 1927

and that death occurred, on the date stated above, at 7 25 m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar Staphylococcus and Septicemia

(duration) Instantaneous yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Dx

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery Date of Burial Sept 28 1927

20 UNDERTAKER: George Schwab ADDRESS 210 Fulton Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E. HAMPSON JONES, M.

Spec.–7-17-26—A Co.—200 Bks.

George Lynn

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25915

CERTIFICATE OF DEATH

E 25915

26-37 74-901

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lynn

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): ? Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Sallie Lynn

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 75 Months – Days –

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER ? George Lynn

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Carroll County Md

12 MAIDEN NAME OF MOTHER ? Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carroll Co Md

14 Informant BALTIMORE CITY HOSPITALS

(Address)

15 Filed SEP 27 1927, 19 HAMILTON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/26/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1927, to Sept 26, 1927, that I last saw him alive on Sept. 26, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - left. Cerebral hemorrhage Arteriosclerosis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Funeral & Sat.

(Signed) C. Holmes Boyd, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Union Cemetery Baltimore Md — Date of Burial: Sept 29 1927

20 UNDERTAKER: Jos Jos Lewis & Son — ADDRESS: 2173 Pa

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25916

CERTIFICATE OF DEATH.

REGISTERED No. 25916

1-PLACE OF DEATH

City of BALTIMORE: (No. 2805 Presbury St 15-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. A. Clemmons

(a) RESIDENCE NO. 2805 Presbury St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Agnes E Clemmons

6 DATE OF BIRTH (month, day, and year): May 9 1888

7 AGE — Years: 39 — Months: 4 — Days: 16 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Smithfield

(State or country) Va

PARENTS

10 NAME OF FATHER: Robert Clemmons

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Lynchburg Va

12 MAIDEN NAME OF MOTHER: Rhoda Gravley

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Smithfield Va

14 Informant: Agnes E Clemmons

(Address) 2805 Presbury St

15 Filed 19 Registrar

HAMPSON JONES M

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

~~Typhoid~~ Organic heart disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) no other diseases

(duration) yrs. mos. ds.

(Signed) S. T. Hennessy M. D.

(Coroner)

Sept 25 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — Date of Burial: Sept 27 1927

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 25917

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25917

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1707 Covington St. (ST.) 24-34 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Hodges.

(a) RESIDENCE NO. 1707 Covington St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced (WIFE) or (HUSBAND) of William Hodges.

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Schemm.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Anna Broseker.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant William Hodges. (husband)

(Address) 1707 Covington St.

15 Filed Sept 27 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26th. 1927

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1927 to September 26 1927

that I last saw h er alive on September 25. 1927

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of the Heart. (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ------

Did an operation precede death? No. Date of ---

Was there an autopsy? No.

What tests confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M Reinhardt, M. D.

9/26 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Hill Cem	Sept 29 1927
UNDERTAKER E. Schlosnagle Son	ADDRESS 1024 Gunnor St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25918

CERTIFICATE OF DEATH

E 25918

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH East Falls. Ave. Eastern Ave.

CITY OF BALTIMORE: (No. ~~Northern~~ 3-5 ST., WARD)

2-FULL NAME Unknown

(a) RESIDENCE NO. " " ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	NK

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
about	45	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unk
(State or country)

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) Unk
(State or country)

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) Unk
(State or country)

14
Informant
(Address)

15
Filed , 192 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

(Signed) Sept 22 1927 M. D.

(Date) , 192 (Address) 1743 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL , 192

20 UNDERTAKER Commissioner Health.

ADDRESS

SEP 23 1927

Wm. F. WOUBALL

THIS IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 25919 HEALTH DEPARTMENT—CITY OF BALTIMORE 001

CERTIFICATE OF DEATH. 16 E 25919

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... St. 64 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Trent

(a) RESIDENCE NO. 215 N. Bond St. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-21-27

7 AGE	Years	Months	Days	If LESS than 1 day, ~~7~~ hrs or ~~1~~ min.
	9 hours	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) — Md

PARENTS

10 NAME OF FATHER Wiley Trent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Leuka Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Virginia

14 Informant Parents
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 9 27 1927, 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Sept 22, 1927, that I last saw her alive on Sept 22, 1927, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

7 month Pregnancy dead abt. 10 hours.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Raymond Weig, M. D.

9/ , 1927 (Address) Johns Hopkins Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 27 1927

20 UNDERTAKER Commissioner Health.

ADDRESS .....

IMPORTANT See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25920

E 25920

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2706 Presbury St., WARD)

2-FULL NAME John Ponder Warren

(a) RESIDENCE No. 2706 Presbury ST., WARD Roanoke Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. E. Warren

6 DATE OF BIRTH (month, day, and year) Oct. 9, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Roanoke Md.

9 BIRTHPLACE (city or town) (State or country) Del.

PARENTS

10 NAME OF FATHER Kendall Warren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Rachael T. Christopher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Mr. Albert J. Warren

(Address) 2706 Presbury St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1927

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1927, to Sept 27, 1927,

that I last saw him alive on Sept 27, 1927

and that death occurred, on the date stated above, at 8.15 A m

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver.

(duration) yrs. 1/2 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. H. C. Kelly, M. D.

(Address) 9/27/27 2757 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehoboth Md. DATE OF BURIAL Sept 29, 1927

20 UNDERTAKER Wm. J. Tucker Sons ADDRESS Norristown Pa

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25921

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 W. Lanley St. 20th WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Khaary

(a) RESIDENCE NO. 2605 Maempel Land St., 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James C. Khaary

6 DATE OF BIRTH (month, day, and year): Aug 23rd 1848

7 AGE — Years: 79 — Months: 1 — Days: 3 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. W. Kendle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary C Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: James W. Khaary

(Address) 231 W. Lanley St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26th 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 12, 1927, to Sept 26, 1927, that I last saw her alive on Sept 26 1927 and that death occurred, on the date stated above, at 3.20 P.M.

The CAUSE OF DEATH* was as follows:

Mitral stenosis

indefinite (duration) yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia (hypostatic)

(duration) yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? 231 W. Lanley

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl. & Phy Exam

(Signed) Fred T. Rogers M. D.

, 19 (Address) 3321 Fredericksburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Sept 28th 1927

20 UNDERTAKER: H.S. Hopkins 1850 N Balto St — ADDRESS

FILED 1927 C. HAMPSON JONES, M. D.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25922 ✓ E 25922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 73

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. 2 ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Moran

(a) RESIDENCE NO. Jacksonville, Fla ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~: Kathleen Moran

6 DATE OF BIRTH (month, day, and year): Oct-4-1888

7 AGE: Years 38 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Vermont

PARENTS

10 NAME OF FATHER: Joseph Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Canada

12 MAIDEN NAME OF MOTHER: Mary Rooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant: Records Johns Hopkins Hospital (Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1927, to Sept. 27, 1927, that I last saw him alive on Sept. 27, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Spinal cord abscess

Brain abscess

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fla

Did an operation precede death? Yes Date of 9-1-27

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Charlton Johnston M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Orangeburg S.C.

DATE OF BURIAL: Sept 28 1927

20 UNDERTAKER: GEO. M. FINK & SON, Geo. M. Fink & Son

ADDRESS 811 N. Wolfe St

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25923

CERTIFICATE OF DEATH.

113 E 25923

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. ____ St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Muslein

(a) RESIDENCE NO. 23 S Chapel St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 Color or Race: White — 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) Aug 21 1927

7 AGE: Years ____ Months 1 Days 5 — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Joseph Muslein

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Benzy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Joseph Muslein

(Address) 23 S Chapel

15 Filed ____, 19 ____ C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 19 27, to Sept 26, 19 27, that I last saw h. alive on Sept 26, 19 27, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted ____

If not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) Mulvey Harris, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial Sept 28 1927

20 UNDERTAKER: Randell Duffield ADDRESS 37 E Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25924

CERTIFICATE OF DEATH

129 E 25924

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1539 Abbottston St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Muldner

(a) RESIDENCE NO. 1539 Abbottston St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Muldner

6 DATE OF BIRTH (month, day, and year) January 11, 1851

7 AGE	Years	Months	Days
	76	8	11

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER John Fenge

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine F. Muldner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Henry Fenge

(Address) 5002 Norwood Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 14th, 1927, to Sept 26, 1927, that I last saw her alive on Sept 26, 1927, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elmer Muldner, M. D.

(Address) 3707 Callaway Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial 9/28/27 19

20 UNDERTAKER Ruth Cook — ADDRESS 1003 W. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-'3—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25925 ✓ 129 E 25925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1645 Hanover St. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Pitcher.

(a) RESIDENCE NO. 1645 Hanover ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68.	1	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Thomas Pitcher.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER George A. Koontz.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Purdy. (Address) 1645 Hanover St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1926, to Sept 26, 1927, that I last saw h[illegible] alive on Sept 26, 1927, and that death occurred, on the date stated above, at 4:40 P m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Hartman M. D.

(Address) 1927 1 E Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Sept 27, 1927

20 UNDERTAKER C. Howard Evans ADDRESS 38 E. Fayette

TION is very important See instructions on back of certificates.

1927 C. HAMPSON Jones M.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25926 E 25926

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1710 Elizabeth La ST. 23-34 WARD

2-FULL NAME Henry Remmers.

(a) RESIDENCE NO. 1710 Elizabeth La. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Rainey Remmers

6 DATE OF BIRTH (month, day, and year): Feb 17, 1859

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gen Repairman 073

(b) General nature of industry, business, or establishment in which employed (or employer): B+O. Retired

(c) Name of employer: B+O.

9 BIRTHPLACE (city or town) (State or country): Germa

PARENTS

10 NAME OF FATHER: Henry Remmers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Grace Rainey Croghan

(Address) 1710 Elizabeth La.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27 19 27.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1927. to Sept 27, 1927.

that I last saw h[illegible] alive on Sept 26, 1927.

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Chronic Parenchymatous nephritis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Aortic Stenosis & Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Postmortem

(Signed) Thos. J. L. Timms, M. D.

9/27, 1927 (Address) 2378 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: 9/30 1927

20 UNDERTAKER: C. Howard Evans ADDRESS: 318 E. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 25927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 Halcyon Park Road ST. 27-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Kirby

(a) RESIDENCE No. 1 Halcyon Park Road ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 17-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Tin-smith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thos H. Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Horney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Sarah Kirby

(Address) 1 Halcyon Park Road

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1927, to Sept 25 1927, that I last saw him alive on Sept 24 1927 and that death occurred, on the date stated above, at 6.15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 15 mos ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. White Jr., M. D.

9/26, 1927 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore cemetery

DATE OF BURIAL Sept 28 1927

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager St

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25928

CERTIFICATE OF DEATH

117 E 25928

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 26-39 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Cermak

(a) RESIDENCE NO. 433 N. Clinton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S. if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie

6 DATE OF BIRTH (month, day, and year) April 20 1863

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	64	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer) Building Assn

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Cermak

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Marie L. Cermak

(Address) 433 N. Clinton St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1927, to Sept 26, 1927, that I last saw him alive on Sept 26, 1927, and that death occurred, on the date stated above, at 11:55 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial failure with acute pulmonary oedema

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis with abscess

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 433 N. Clinton St

Did an operation precede death? Yes Date of Sept 22, 1927

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) R. S. Anderson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill Cemetery — Date of Burial Sept 29 1927

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E. Eager St.

OCT 1927 C. HAMPSON JONES, M. D.

Per ROH

DO NOT WRITE IN SPACE ABOVE. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25929 | E 25929

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 21 Evergreen ave (St.) 27-43 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma F Potee

(a) RESIDENCE NO. 21 Marquette (St.) (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. H. Potee

6 DATE OF BIRTH (month, day, and year): Mar 3rd 1855

7 AGE: Years 72 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A A Co Md

PARENTS

10 NAME OF FATHER: Chas Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): A A Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A A Co Md

14 Informant: Geo. Potee

(Address): 21 Evergreen Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26/27, 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 5/27, 19 to Sept 26/27, 19

that I last saw h alive on Sept 26/27, 19

and that death occurred, on the date stated above, at 5 PM m.

The CAUSE OF DEATH* was as follows:

Hemiplegia, (Cerebral)

(duration) Yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary): Nephritis, Hypertension

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John B Coll, M. D.

Sept 29, 19 (Address) 1 W 39th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedarhill Cemetery — DATE OF BURIAL: 9/29 1927

20 UNDERTAKER: Robert Brookerson — ADDRESS: Calhoun Hoelins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 25930

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25930
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2930 Bernard St. 12 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mary D. Goodwin

(a) Residence No. 2930 Bernard St. 12 Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Goodwin

6-DATE OF BIRTH (month, day and year): Aug 14th 1851

7-AGE: 76 yrs. 1 mos. 12 ds.

If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work:

(b) General nature of Industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Hinsdale N. Y.

PARENTS:

10-NAME OF FATHER: Abner Bates

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known

12-MAIDEN NAME OF MOTHER: Mary D. Bates

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14-

(Informant): Charles Goodwin

(Address): 2930 Bernard St

15-

Filed ..... 192.. Registrar.

R Hall

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 26th 27

17- I HEREBY CERTIFY, That I attended deceased from May 3rd, 1927 to Sept 26th 1927 that I last saw h.. alive on Sept 25th 1927 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows: Chr Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. G. Cross M. D.

, 19 (Address) 28 W 25th St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Sept 29, 1927
20-UNDERTAKER	ADDRESS
Thomas Dolan	3615 Chestnut Ave

In plain terms, so that it may be properly classified. Exact name of disease, not symptoms or mode of dying. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25931

E 25931

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

REGISTERED NO. 100-001

CITY OF BALTIMORE: (No. Lafayette Ave. St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Jacobs

(a) RESIDENCE NO. 121 ashland ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1881

7 AGE 46 Years — Months — Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Talor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER John R Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Barbar Matos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Joseph Jacobs

(Address) 427 W Pratt Street

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26. 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/20/27. 19 . to 9/26/27. 19 , that I last saw him alive on 9/26/27. 19 , and that death occurred, on the date stated above, at 11 20 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobular)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Clinical Signs

(Signed) ... M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept 22. 1927

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S Paca St

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25932

CERTIFICATE OF DEATH

90 E 25932

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 223 N. Patterson Pk Ave. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Strickrotte

(a) RESIDENCE NO. 223 N. Patterson Pk. St. 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S. if of foreign birth 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary K. Strickrotte.

6 DATE OF BIRTH (month, day, and year) Jan 31st 1853

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	74	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired City

(b) General nature of industry, business, or establishment in which employed (or employer) Watchman

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Thomas Strickrotte

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunda Huenmert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary K. Strickrotte

(Address) 223 N. Patterson Pk

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 19 27 to Sept 24 19 27

that I last saw h wife alive on Sept 24 19 27

and that death occurred, on the date stated above, at 12 noon p.m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation (Chronic)

(duration) 1 yrs. mos.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Maryland

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Findings

(Signed) Wm. H. Welch M. D.

19 (Address) 100 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — Date of Burial Sept. 28 1927

20 UNDERTAKER Lilly & Gilden — ADDRESS 1038 W. Lafayette

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 25933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 25933

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 508 S. Eurley St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Norma Bombardt

(a) RESIDENCE NO. 508 S. Eurley St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 4 mos. 23 ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4th 1910

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	17	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stripping Dept

(b) General nature of Industry, business, or establishment in which employed (or employer) Fun Dec. Co

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Charles Bombardt

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Carrie Bieggerman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md

14 Informant Charles Bombardt

(Address) 508 S. Eurley

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1927

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1927 to Sept 27, 1927

that I last saw h[illegible] alive on Sept 26, 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis.

..... (duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) None

..... (duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick W Burman, M. D.

(Address) 1708 E Lan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — Date of Burial Sept 30th 1927

20 UNDERTAKER Lilly & Zeiler — ADDRESS 403 N Wolfe St

Rec'd SEP 28 1927 HARRISON BUR. OF VITAL STATISTICS

Prt

IF DEATH OCCURRED IN A HOSPITAL OR INSTITUTION, the NAME should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 25934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1855

E 25934

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Pavement 1, 714 E. Pratt St. Chan 9 St. 9th Ward)

2-FULL NAME John J. Maguire or in nav. a mate, ship

(a) RESIDENCE NO. Greenmount Av. 4021 St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 13, 1896

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Chas. Crud. Co.

9 BIRTHPLACE (city or town)_____

(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Maguire

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Catherine Robinson

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Baltimore

14 Informant Ed. Maguire

(Address) 4021 Greenmount Av.

15 Filed_____, 19_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Vertebrae. (Broken back.) Caused by accidentally falling from 3-floor Chandler Bldg. Duration Instant yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Sept. 29 27 (Signed) W. C. Peter (Coroner) M. D.

(Address) 1035 Guilford Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial 9/29 1927

20 UNDERTAKER Henry B. Myers & Son ADDRESS 805 N. Calvert

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25935

CERTIFICATE OF DEATH

100-001

E 25935

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pete Levandowski

(a) RESIDENCE NO. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bertha Levandowski

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 19 27, to Sept. 27, 19 27,

that I last saw him alive on Sept. 27, 19 27,

and that death occurred, on the date stated above, at 3.55 A. m.

The CAUSE OF DEATH* was as follows:

Obscure

(duration) yrs. mos. ds.

CONTRIBUTORY Lobular pneumonia
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Henry C Smith, M. D.

9-27 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Sept 29 19 27

Date of Burial

20 UNDERTAKER J W Ozazewski

ADDRESS 1930 Eastern Ave

SEP 29 1927 C. HARRISON REG

IMPORTANT. See instructions on back of certificates.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible] should be entirely supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 25936
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 25936
REGISTERED NO.

City of BALTIMORE: (No. 13 E. Franklin St. 4-7 Ward)

2-FULL NAME Doreen Dale

(a) RESIDENCE NO. 13 E. Franklin St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of J. D. Dale

6 DATE OF BIRTH (month, day, and year) June 1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ~~None~~ work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER J. W. Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Sallie Hackett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant J. W. Wilson
(Address) Fort Washington Md

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Val. disease heart
Some years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) Two years yrs. mos. ds.

Signed W. J. Riley (Coroner) M. D.

Sept 27/27 .19 (Address) W. J. Riley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Relenburg Va Date of Burial Sept 29 1927

20 UNDERTAKER J. J. Tucker, Sons ADDRESS Ft Pa Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25937

CERTIFICATE OF DEATH.

188-003

E 25937

REGISTERED NO.

1-PLACE OF DEATH In front of

City of BALTIMORE: (No. 1211 Briscoe St. St. 41-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Domnick Defina

(a) RESIDENCE NO. 1215 Briscoe St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)
Febfuary 23, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Camillo Defina.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy.

12 MAIDEN NAME OF MOTHER Mamie Tarr.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Mamie Defina.(mother)

(Address) 1215 Briscoe St.

15 Filed ....., 19 . HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 27, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed skull
Run over by auto truck.
Accidental Death.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

Signed Otto R. Ensminger M. D.
(Coroner)

9/28 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial 9/28 19 27

20 UNDERTAKER John L. Emmerson ADDRESS 901 E. Fallsway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25938

CERTIFICATE OF DEATH.

129 E 25938

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Poplar Grove ST. 16-67 WARD)

2-FULL NAME Mary Elizabeth Levy.

(a) RESIDENCE NO. 1120 Poplar Grove ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of Harry E. Levy

6 DATE OF BIRTH (month, day, and year) July 10th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63.	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edward McDorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine Gorman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr Harry E Levy.

(Address) 1120 Poplar Grove St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27th 1927.

17

I HEREBY CERTIFY, That I attended deceased from March 10th, 1926, to Sept 27th, 1927, that I last saw her alive on Sept 27th, 1927, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) One yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical + Urinalysis.

(Signed) Wm. Sullivan, M. D.

9/28 1927 (Address) 1701 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Sept 30th 1927

20 UNDERTAKER: John J. Cavanaugh & Son ADDRESS: 901 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25939

CERTIFICATE OF DEATH

40 E 25939

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 915 S Sharp St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dare

(a) RESIDENCE NO. 915 S Sharp St. 23 Ward 23

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29 1901

7 AGE: Years 25 Months — Days 26 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

(c) Name of employer: Swindell Co.,

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER John Dare

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Ora Dixon

(Address) 915 S Sharp St.

15 Filed ..... 19 .....

Registrar

SEP 26 1927 C. HAMPSON REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/25/1927

17 I HEREBY CERTIFY, That I attended deceased from 9/2/1927 to 9/25/1927

that I last saw h[illegible] alive on 9/24/1927

and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

about (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Intoxicate

Rheumatism about

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John Conley M. D.

9/2, 1927 (Address) 905 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

H.P. Cemetery 9/27

20 UNDERTAKER — ADDRESS

Samuel Kennedy 1711 Bolton

IMPORTANT—Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25940

CERTIFICATE OF DEATH.

90 ✓

E 25940

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1006 Madison ave Sl. 10-14 Ward)

2-FULL NAME Frank Spencer

(a) RESIDENCE NO. 1006 Madison ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy Spencer

6 DATE OF BIRTH (month, day, and year): About 1861

7 AGE — Years: 66 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): W. Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Mary Woods

(Address) 1006 Madison ave.

15 Filed....., 19 MAY Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) see history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Sept. 26 1927 (Address) 2572 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charlestown West Va — Date of Burial: Sept 28 1927

20 UNDERTAKER: David Easton — ADDRESS 916 Pine

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 25941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25941
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1715 Myrtle Ave St. 17-24 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James O. Young

(a) RESIDENCE NO. 1715 Myrtle Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Irene Young

6 DATE OF BIRTH (month, day, and year): June 21 1886

7 AGE: Years 41 Months 4 Days 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baggageman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Henry Young

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: May Forbes

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Irene Young

(Address): 1715 Myrtle Ave

15 Filed....., 19..... [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..yrs. ..mos. 1 ds.

CONTRIBUTORY (Secondary) no other history

(duration) ..yrs. ..mos. ..ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Sept. 27, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemty Date of Burial 9/29 1927

20 UNDERTAKER: Thos Geo. E. Collins ADDRESS: 163 Druid Hill ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 25942

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH E 25942

County Baltimore

Registration Dist. No. 105

Village or City Govans (No. 417 Druid Lane) St. Ward 57-46

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William H. Hitchens

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 ~~SINGLE~~ MARRIED ~~WIDOWED OR DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: Sept (Month) 26 (Day) 1880 (Year)

7 AGE: 47 yrs. 7 mos. 8 ds. If LESS than 1 day .... hrs. or .... min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed or (employer): Self

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: J. J. Hitchens

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mariah Johnson

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary J. Hitchens

(Address) 417 Druid Lane

15 Filed ..... 192 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 26 (Day) 1927 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 1 1927 to Sept 26 1927.

that I last saw h[im] alive on Sept 26 1927,

and that death occurred on the date stated above, at 8 P m.

The CAUSE OF DEATH * was as follows:

Cystitis

(Duration) x yrs. 6 mos. 26 ds.

Contributory Secondary: Renal Insufficiency

(Duration) ..... yrs. 3 mos. 2 ds.

(Signed) Dr. J. E. Bauman M.D.

Sept 27 1927 (Address) 610 York Road

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 16 yrs. x mos. x da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Zion Cemetery Govanstown

DATE OF BURIAL: Sept 29 1927

20 UNDERTAKER: Edwin Alexander

ADDRESS: 1406 Druid Hill Ave

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

CIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25943

CERTIFICATE OF DEATH.

90

E 25943

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 642 S. Ellwood St. 1-2 Ward)

2-FULL NAME Robert Alchin

(a) RESIDENCE NO. 642 S Ellwood St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2 - 1908

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	19	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Page

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Belvidere Hotel

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Harry Alchin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Canada

12 MAIDEN NAME OF MOTHER Minnie Feldman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Minnie Cowan.

(Address) 642 S Ellwood ave.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Sinusoid

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) C. Laws Fine

(Duration) ..... yrs. mos. 1 ds.

Sept 28 27 (Signed) G. C. Page, M. D.

19 (Address) 1436 Druid Pkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Cemetery	Sept 30 1927

20 UNDERTAKER George W. Zirkler ADDRESS 1737 E Eager St

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25944

CERTIFICATE OF DEATH.

E 25944

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 245 N. Monroe St. 10-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie E Evans

(a) RESIDENCE. No. 245 N. Monroe St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John L Evans

6 DATE OF BIRTH (month, day, and year): Nov 11, 1860

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
66	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Kate E Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: John L Evans
(Address): 245 N Monroe St

15 Filed SEP 28 1927 19 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1927, to Sept 26, 1927, that I last saw h[e] alive on Sept 26, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J Murray, M. D.

9-27, 1927 (Address) 510 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: Sept 29 1927

20 UNDERTAKER: George J Smith

ADDRESS 1532 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25945

CERTIFICATE OF DEATH

× 38

E 25945

REGISTERED NO.

1-PLACE OF DEATH Univ Hospital

City of BALTIMORE: (No. 4-20 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Martin Peek

(a) RESIDENCE NO. Baltimore Md St: Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1899

7 AGE: Years 27 ~~1899~~ Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Maryland

PARENTS

10 NAME OF FATHER: M. Peek

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ga

12 MAIDEN NAME OF MOTHER: Ella Stewart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ga

14 Informant: Mrs Annie Alexander

(Address) 724 Beach 88 St. N.Y. Rockaway

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1927 to Sept 26, 1927

that I last saw him alive on Sept 26, 1927

and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis 5 yrs

Abdominal Ascites 5 days

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. A. Lumpkin, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Crawfordville Ga.

Date of Burial: Sept 30 1927

20 UNDERTAKER: Harry B Nutzke

ADDRESS 1531 Eutaw St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 25946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

REGISTERED NO. E 25946

1-PLACE OF DEATH

City of BALTIMORE: (No. 1507 E. Fairmount Ave St. 6-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Moore

(a) RESIDENCE NO. 1507 E. Fairmount Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Moore

6 DATE OF BIRTH (month, day, and year) Dec. 4-1884

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	82	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. W. Jones

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Rebecca A. Taylor

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant David J. Jones

(Address) 524 N. Bethel St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 192 to Sept 25, 192, that I last saw her alive on Sept 24, 192, and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Richard H. Essinger, M. D.

, 19 (Address) 1514 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — Date of Burial 9/28 1927

20 UNDERTAKER Chas. H. Johnson — ADDRESS 716 N. Broadway St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 25947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177 E 25947

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

City of BALTIMORE: (No. JohnsHopkins Hospital St. 26-11 Ward)

2-FULL NAME Ida Elizabeth Hauser

(a) RESIDENCE NO. 3329 E. Monument St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 18/24

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Geo. F Hauser

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Rith E. Schoner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Geo. F. Hauser

(Address) 3329 E. Monument St

15 Filed 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 27/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to HER death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strychnia Poisoning-Accidental

(Self administered- Alophen tablets

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Paten M. D.

(Coroner)

9/28-27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Date of Burial 9/29 19

20 UNDERTAKER L Heemann ADDRESS 32 S Bway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 7-17-26—A Co.—200 Bks.

E 25948 HEALTH DEPARTMENT—CITY OF BALTIMORE E 25948

CERTIFICATE OF DEATH

X 101-001

1-PLACE OF DEATH — REGISTERED NO. 30

City of BALTIMORE: (No. Hmerrsely Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Lipton

(a) RESIDENCE NO. Hampstead, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) ? ? 1848

7 AGE Years 79 Months ? Days ? IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/23, 1927, to 9/28, 1927

that I last saw him alive on 9/28, 1927

and that death occurred, on the date stated above, at 11 A.m.

The CAUSE OF DEATH* was as follows:

Uremia

Chronic Nephritis x years

(duration) unknown yrs. mos. da.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 9/27/27

Was there an autopsy? No

What test confirmed diagnosis? Chemical & Laboratory

(Signed) F. F. Tuska, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampstead, Md — Date of Burial Sept 28 1927

20 UNDERTAKER J. J. Lucken Sons — ADDRESS Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 26 1927 C. HAMPSON JONES, M.D. Per

Cor.—12-9-25—A Co.—200 Bks.

E 25949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 E 25949

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) South Baltimore General Hospital (Ward) 16-22

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander McCloskey.

(a) RESIDENCE NO. 1012 N. Appleton St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) May 9, 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Philadelphia, Pa

PARENTS

10 NAME OF FATHER Henry McCloskey.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Boyle.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant Maggie Gibson. (sister)

(Address) 1012 N. Appleton St.

15 Filed ..... 19 .....

For C. HAMPSON JONES, M. D. Registrar

SEP 28 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 26, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Bernhardt M. D.
(Coroner)

9/27 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

42 E. York St.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mon Cathedral Date of Burial Sept 29 19 27

20 UNDERTAKER H. M. Cook ADDRESS 532 E Madison

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Dr Miller 1500 N Broadway

E 25950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 25950

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 East North Ave ST. 9-18 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Durnin

(a) RESIDENCE NO. 506 East North Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E Durnin

6 DATE OF BIRTH (month, day, and year) Oct 10, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Benjamin Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cynthia Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Geo L Durnin (Address) 506 E North Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1927

17

I HEREBY CERTIFY, That I attended deceased from 8/14 . 1927 . to 9/27 . 1927.

that I last saw her alive on 9/27 . 1927.

and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr Int Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Dane Miller, M. D.

9/28/27 (Address) 1500 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary Hampden — DATE OF BURIAL Sept 30 1927

20 UNDERTAKER J. Cook — ADDRESS 512 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25951

CERTIFICATE OF DEATH.

161-001

E 25951

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 75-72 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Snead

(a) RESIDENCE NO. 421 F. St. Sparrows Point St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-27-27

7 AGE	Years	Months	Days	If LESS than 1 day 3½ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Warner Snead

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Lillian Harris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs. Lillian Snead

(Address) 421 F. St. Sparrows Point

15 Filed ___ 19___ C. HAMPSON JONES, M. D.

Per ___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 9-28-27

17 I HEREBY CERTIFY, That I attended deceased from 9-27 1927, to 9-28 1927,

that I last saw him alive on 9-28 1927,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum (Prematurae)

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) (Heart beat 3½ Pounds)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. L. Dedagliacca, M. D.

, 19 (Address) St Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. Date of Burial Sept 29/1927

20 UNDERTAKER John J. Cowan & Son ADDRESS 90 Hallins

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Blks.

E 25952

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 25952

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals, St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Ed. Smith

(a) RESIDENCE NO. 215 S. Durham st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Edw. Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10 19 27, to Sept. 25 19 27

that I last saw him alive on Sept. 25 19 27

and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & clinical

(Signed) Henry C. Smith M. D.

9-26 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Commissioner Health

Per Wm. E. Woodall

SEP 29 1927

UNIVERSITY OF MARYLAND

C. THOMPSON

1. B.—WRITE LEGIBLY. Typewriter should be used if possible. All items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

336

1710 RRH

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25953

CERTIFICATE OF DEATH

E 25953

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St. [redacted] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Nelson

(a) RESIDENCE NO. 228 Rose St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Indiana

PARENTS

10 NAME OF FATHER James Nelson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Nelson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant [redacted] CITY HOSPITALS

(Address) [redacted]

15 Filed ..... 19 .....

Registrar

1711 DRN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/25/ 1927

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1927 to Sept. 25, 1927

that I last saw him alive on Sept. 20, 1927

and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Semeiology & Symptoms

(Signed) C. Hudson Owings, M. D.

, 19 (Address) CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

UNIVERSITY OF MARYLAND

Date of Burial

19

20 UNDERTAKER

ADDRESS

Commissioner Health.

By: Wm. E. JORDAN

SEP 28 1927

N. B.—WRITE PLAINLY, WITH CARBON PENCIL OR PEN AND INK. NAME should be stated EXACTLY. PHYSICIANS should state CAUSE tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25954 ✓ E 25954

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 S Clinton St. 26-2 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Bunk

(a) RESIDENCE NO. 328 S Clinton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 18 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	32	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Sewing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Bunk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rose Banmach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Rose Bunk
(Address) 328 S. Clinton St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Sep 22 1927 to Sep 26 1927.
that I last saw her alive on Sep 26 1927
and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Articular Rheumatism

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Louis Ogle M. D.

9/27/27 (Address) 1600 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL Sept 30 1927

20 UNDERTAKER John F. Weber ADDRESS 1803 Eager St.

SEP 28 1927 C. HAMPSON JONES, M.D.

Information should be carefully supplied. AGE should be stated in years. Exact statement of OCCUPATION is very important. See Instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-12-23—M&T—500 Bks.

(Morgal)

E 25955

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 E 25955

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary 22-41 ST. (or Ward) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Louise-Morgal

(a) RESIDENCE NO. 4218 Belair Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 8 mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harold S. Morgal

6 DATE OF BIRTH (month, day, and year) May 9 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	23	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sioux Dakota

PARENTS

10 NAME OF FATHER Thomas Tinker

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Dakota

12 MAIDEN NAME OF MOTHER Agnes Otto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Dakota

14 Informant Harold S. Morgal (Address) 4218 Belair Rd.

15 Filed 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1927, to Sept 28, 1927, that I last saw her alive on Sept 27, 1927, and that death occurred, on the date stated above, at 3.50 p m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis & insufficiency

Myocardial Incompetency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Streptococcal Septicemia

(duration) 0 yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) Raymond Kerr, M. D.

9/28 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PARKWOOD CEMETERY	9/30/27 19

20 UNDERTAKER Kreiling Co

ADDRESS 1003 W. Baltimore S

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

P 6 1927 HAMPSON JONES, M.D.

Cor.—12-9-25—A Co.—200 Bks.

(Salvino Agricomi)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25956

E 25956

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 3-5, Ward)

2-FULL NAME Salvatore Agricomi

(a) RESIDENCE NO. 318 President St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Agricomi

6 DATE OF BIRTH (month, day, and year) July 17 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Agricomi

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Mrs. Agricomi

(Address) 323 President St

15 Filed ..... 19 .....

ACH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:*

Acc Fall.

Fracture of Skull.

(Over)

Duration ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

Duration ..... yrs. ..... mos. 2 ds.

Signed ..... M. D.

(Coroner)

Sept 27 1927 (Address) 143 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents — Date of Burial: Sep 29 1927

20 UNDERTAKER: Kendall Dippold — ADDRESS: 37 S Amer

N. B.—Blanks must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 25957

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25957

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 129

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. [illegible] Ward) 11-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wanda Scarborough

(a) RESIDENCE NO. 440 Orchard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Records

15 Filed 19

Registrar

ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/26/1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1927, to Sept 26, 1927, that I last saw him alive on Sept 26, 1927 and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic acute interstitial. Hypertension Chronic interstitial nephritis

(duration) yrs. 3 mos. da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? ? Date of

Was there an autopsy? No

What test confirmed diagnosis? Gen. Symptoms & Symptoms

(Signed) C. Holmes Boyd, M. D.

, 19 (Address) CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Auburn

Date of Burial Sept 29 1927

20 UNDERTAKER

Hamel Eastern

ADDRESS 916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25958

CERTIFICATE OF DEATH.

114 E 25958

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1026 Penna. ave St. 17-24 Ward)

2-FULL NAME Ethel Powell

(a) RESIDENCE NO. 1026 Penna ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race female colored

5 Single, Married, Widowed, or Divorced. (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1903

7 AGE Years 24 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) (10 Sept. 25 1927)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John Powell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Nelson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Geo. Housewood

(Address) 1026 Penna ave

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. Decubitus of Sacrum

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) ac Cardio-Enteritis

(duration) yrs. mos. 1 ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

19 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Sept 25 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Pa ave

NOTE.—WHITE PAPER. TYPEWRITER PREFERRED. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 25959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25959

REGISTERED NO. 114

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 92 Middle Court 12-24 Ward)

2-FULL NAME Hazel Campbell

(a) RESIDENCE NO. 92 Middle Court St. 12 Ward

(Usual place of abode)

Length of residence in city or town where death occurred City yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Berry Campbell

6 DATE OF BIRTH (month, day, and year) about 1897

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Jarmiah Crowner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine Brooks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Berry Campbell
(Address) 92 Middle Court

15 Filed 19
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. dil. of heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ac. bronchitis

(duration) yrs. mos. ds.

(Signed) O. T. Kennedy M. D.
(Coroner)

Sept 27 19 27 (Address) 2572 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Sept 29 19 27

20 UNDERTAKER: Daniel Easton ADDRESS 916 Pine

N. B.—WHERE PHYSICIANS are required to report cases to the Health Department, the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25960

CERTIFICATE OF DEATH.

66 E 25960

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Jmw Hospital St. 17-24 Ward)

2-FULL NAME Daisy Patrick

(a) RESIDENCE NO. 538 Fremont St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1901

7 AGE — Years: 26 — Months: — — Days: — — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Boston

(State or country)

PARENTS

10 NAME OF FATHER: Dont know

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Dont know

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Dont know

14 Informant: John Matthews

(Address): 538 Fremont St

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism (Duration) yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) _____ (Duration) yrs. ____ mos. 1 ds.

Sept 28 1927 (Signed) G C Yates (Coroner), M. D.

(Address) 1431 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Sept 29th 27

20 UNDERTAKER: Howard Easton ADDRESS 916 Pine

N. B.—WRITE PLAINLY. All questions should be carefully answered. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be very important. See instructions on back of certificate. OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25961

CERTIFICATE OF DEATH.

E 25961

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 522 Burgundy St. 12-30 Ward)

2-FULL NAME Robt Maddox

(a) RESIDENCE NO. 522 Burgundy St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) md

PARENTS

10 NAME OF FATHER Joe Maddox

11 BIRTHPLACE OF FATHER (city or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Priscilla Clemons

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14 Informant Sophia Woodland

(Address) 524 Burgundy

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to _____ death on the day stated above.

The CAUSE OF DEATH was as follows:

Ac Alcoholism

(Duration) 1 yrs. ____ mos. 1 ds.

CONTRIBUTORY (Secondary) _____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) G E Ladd M. D.

(Coroner)

9/27 19 (Address) 143 W Gray

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

Date of Burial Sept 29 19 27

20 UNDERTAKER Dennis Easton

ADDRESS 916 Pa

N. B.—WRITE PLAINLY, with pen and ink. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be carefully supplied.

Spec.—12-9-25—A Co.—200 Bks.

E 25962

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25962

CERTIFICATE OF DEATH.

15-65 X-4-K

1-PLACE OF DEATH

City of BALTIMORE: (No. 2905 Lyndhurst St. St. 15 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank E. Nickerson

(a) RESIDENCE NO. 2905 Lyndhurst St. Ward Quincy Mass

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25, 1861,

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
66	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Mechanic,

(b) General nature of industry, business, or establishment in which employed (or employer) Of

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Mass.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Clarence W. Nickerson

(Address) 2905 Lyndhurst St.

15 Filed ..... 19 .....

RPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Sept 28

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1927, to Sept 28, 1927,

that I last saw h[illegible] alive on Sept 28, 1927,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Multiple Sarcoma

Involving Arm Jaw

Jaw + Face

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Manchuria

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Abnormal

(Signed) A. C. Smith, M. D.

Sept 28 1927 (Address) 4209 Peabody Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Quincy Mass. Date of Burial Sept 29 1927

20 UNDERTAKER Wm C. Black ADDRESS 927 N Broadway

N. B. [illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-801

E 25963

CERTIFICATE OF DEATH.

E 25963
1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 214 S. Washington St., 2-4 Ward)

2-FULL NAME Andrew Fritz.

(a) RESIDENCE NO. 214 S. Washington Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Annie C. Fritz

6 DATE OF BIRTH (month, day and year): March 15 1862

7 AGE: Years 65 Months 6 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Not Known

14 Informant: Annie Fritz
(Address): 214 S Washington St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) C. C. Blades M. D.
(Coroner)
(Address) 143 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Date of Burial 9-30 1927

20 UNDERTAKER: Walter Schloman ADDRESS: Alexandria Va.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25964

CERTIFICATE OF DEATH.

90 E 25964

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2314 Hunter st St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgeanna Chamberlain.

(a) RESIDENCE NO. 2314 Hunter st St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/10/06

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	21	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 07

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Louise Locke

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Md & Del

14 Informant Georgie Cook

(Address) 2314 Hunter st.

15 Filed_____, 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Calculus

Disease of Heart

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) David Morrison M. D. (Coroner)

9/28 1927 (Address) 322 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Auburn	Sept. 29 1927

20 UNDERTAKER	ADDRESS
Wm. R. C. Elliott	1715 Eastland ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

25965 E

CERTIFICATE OF DEATH.

33E 25965

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 E. Eager ST., 1-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mahala Thomas

(a) RESIDENCE NO. 1726 E Eager ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced (~~HUSBAND of~~) or) WIFE of Wm. H Thomas

6 DATE OF BIRTH (month, day, and year) month unknown 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 37

(b) General nature of industry, business, or establishment in which employed (or employer) Housework at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) King Geo. County Va

PARENTS

10 NAME OF FATHER Seaman Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) King Geo Co. Va

12 MAIDEN NAME OF MOTHER Katie Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Wm H Thomas Husband 1726 E Eager St

15 Filed , 19 R L V Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1927

17

I HEREBY CERTIFY, That I attended deceased from March , 1927 , to Sept 27 , 1927 ,

that I last saw her alive on Sept 25 , 1927 ,

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Upshur M. D.

9/28 1927 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Lawn

DATE OF BURIAL Sept 30, 1927

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1725 Ashland Ave

CAUSE OF DEATH should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25966 — PLACE OF DEATH

129 E 25966 — REGISTERED NO. C

CITY OF BALTIMORE (No. 819 Chauncey ave 13-59 ST. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Balser

(Residence in Baltimore: No. 819 Chauncey ave St.; 44 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Unknown (Month) (Day), 1839 (Year)

7 AGE: 88 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: old age
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: Joseph Hackesman

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dina

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nathan Balser

(Address) 819 Chauncey ave

15

Filed ... 191 ... RFH REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 28 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept-15- 1927. to. Sept-28- 1927.
that I saw her alive on Sept-28 1927.
and that death occurred, on the date stated above, at 2.30 p.m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) about 3 yrs yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), Herman Seidel M. D.
Sept-28, 1927. (Address) 2404 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore Hebrew Cem. DATE OF BURIAL: 9/29/27

20 UNDERTAKER: Jack Levin ADDRESS: 1739 E Balt St

SEP 29 1927

Cor.—12-9-25—A Co.—200 Bks.

E 25967

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 900 W. Fallsway St. 16-23 Ward)

REGISTERED NO. 191

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barney Robuone

(a) RESIDENCE NO. 704 N Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	C.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) [illegible] 1898

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Florida
(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) [illegible]

14 Informant Mrs. R. A. Elliott
(Address) 1725 Ashburton Ave

15 Filed, 19 (Registrar)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 25 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Homicide Gun Shot wounds 2 Stabs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Date of Burial Sept 29 1927

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Ashland Ave

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 29 1927 C. HAMPSON JONES, M.D.

Spec.–7-17-26–A Co.–200 Bks.

E 25968 Marie Pack

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25968 ✓

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Pack

(a) RESIDENCE NO. 1518 Eager st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Pack

6 DATE OF BIRTH (month, day, and year)
1906

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Smith

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed SEP 29 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
September 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 19 27, to Sept. 26, 19 27, that I last saw her alive on Sept. 26, 19 27, and that death occurred, on the date stated above, at 2.55 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory

(Signed) Henry C Smith M. D.

9-26-, 19 27 (Address) City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary — Date of Burial Sept 29 1927, 19

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS Maryland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25969

CERTIFICATE OF DEATH.

E 25969

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 1-1 WARD)

2-FULL NAME Marie Stanton

(a) RESIDENCE NO. 929 South Ellwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 19, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry Stanton

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Louis Mo.

12 MAIDEN NAME OF MOTHER Annie Kelby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mich

14 Informant Harry Stanton

(Address) 929 S. Ellwood ave

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1927, to Sept 28, 1927, that I last saw h[illegible] alive on Sept 28, 1927 and that death occurred, on the date stated above, at 3 00 P m.

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bac. Cult.

(Signed) Myron G. Lucas, M. D.

9/29, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Cemetery DATE OF BURIAL: Sept 29, 27

20 UNDERTAKER: D. J. Marshall ADDRESS: 3539 Fall Rd

mation should be carefully supplied. AGE should be stated EXACTLY. If CHILDREN under one year, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 25970 — 90 — E 25970

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2211 Roslyn ave. St., 15-60 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah V. Crane

(a) RESIDENCE NO. 2211 Roslyn Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE — Years: 69 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home duties

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town): St Marys Co

(State or country): Md

PARENTS

10 NAME OF FATHER: Robert Crane

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah B. Matte

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Isabelle G. Crane

(Address): 2211 Roslyn ave

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Sept. 28. 27

17 I HEREBY CERTIFY, That I attended deceased from May 1st. 19 27 to Sept. 28 19 27

that I last saw her alive on Sept. 27th 19 27

and that death occurred, on the date stated above, at 12.45a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Heart-acute dilitation

10 minutes (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual Signs

(Signed) D. A. Waldran, M. D.

, 19 (Address) 210 E Preston St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

London Park Sept 30 19

20 UNDERTAKER — ADDRESS

John O. Mitchell & Sons

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25971

CERTIFICATE OF DEATH.

74-001

E 25971

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 912 N. Eutaw St. 11-24 Ward)

2-FULL NAME Henrietta Kelley

(a) RESIDENCE NO. 912 N. Eutaw St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): about 1877

7 AGE: Years: 50 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: General

9 BIRTHPLACE (city or town)..... (State or country) Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)..... (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)..... (State or country)

14 Informant Eliza Gregory (Address) 915 N. Eutaw St.

15 Filed..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Kidney

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Turner M. D. (Coroner)

Sept. 27 19 27 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cmtry Date of Burial: Sept 29 1927

20 UNDERTAKER: J. Leon Hall ADDRESS: 1753 Dolphin

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25972

CERTIFICATE OF DEATH.

161-001

E 25972

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital S. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Girl Smith

(a) Residence No. 1014 Carrollton Ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

should be carefully supplied. AGE should be stated EXACTLY. Answers to questions in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 9/19/27

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 45 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Clara Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Northumberland Co Va

14- (Informant).....

(Address).....

15- Filed SEP 29 1927 19.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9/19/27

17- I HEREBY CERTIFY, That I attended deceased from 9/19, 1927 to 9/19 1927, that I last saw h[illegible] alive on 9/19 1927 and that death occurred, on the date stated above, at 7.45 P.m.

The CAUSE OF DEATH* was as follows:

Prematurity

.....(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary).....

.....(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Knight Reynolds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Wife. Cremated

DATE OF BURIAL, Sept. 20 1927.

20-UNDERTAKER.

ADDRESS

Spec.–7-17-26—A Co.—200 Bks.

Jeane Bagert.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25973

CERTIFICATE OF DEATH

X 114 E 25973

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hosp. St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bagert, Jeane

(a) RESIDENCE NO. Westminister, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year): November, 1924

7 AGE — Years: 2 Months: 10 Days: IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): d

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Penn.

PARENTS

10 NAME OF FATHER Samuel Bagert

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Penn.

12 MAIDEN NAME OF MOTHER Alice Dutton

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Penn.

14 Informant: John R. Byers

(Address) Westminster Md.

15 Filed ..... 19 ..... Registrar

SEP 5 1927 C. HAMPTON GIBBONS M D

To be OK by coroner.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Sept. 28. 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-28, 1927, to 9-28, 1927,

that I last saw her alive on 9-28, 1927,

and that death occurred, on the date stated above, at 11:25 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal intoxication with convulsions

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Intestinal intoxication with convulsions

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

if not at place of death? at Westminster, Md.

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Teague, M. D.

, 19 (Address) County Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: F. F. Reese Westminster — Date of Burial: Dec. 2 19 27

20 UNDERTAKER: Orford Co. — ADDRESS: Westminster.

G. & B. Bader. M. Coroner at Cogs

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25974

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

3 E 25974

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1749 Mulliken ST., 6 9 WARD)

2-FULL NAME Johan Brooks

(a) RESIDENCE NO. 1749 Mulliken ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Benny Brooks

6 DATE OF BIRTH (month, day, and year): March 9 1844

7 AGE: Years 83 (87) Months 6 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Marys Co, Md.

PARENTS

10 NAME OF FATHER: James Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co, Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co Md

14 Informant: Sonia Ballard

(Address) 1749 Mulliken St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/27/ 19 27

17 I HEREBY CERTIFY, That I attended deceased from 8/29/, 19 27, to 9/27, 19 27, that I last saw ~~he~~ alive on 9/26/, 19 27, and that death occurred, on the date stated above, at 7.10 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Cardiac Dilatation & pulmonary Hypostasis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Senility, Bronchitis

Tuberculosis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & History

(Signed) W W Bishop M. D.

, 19 (Address) 709 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL: Sept 30 1927

20 UNDERTAKER: Robt. F. Wilkins — ADDRESS: 1515 Mc Elderry St

mation should be carefully supplied. Age should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION of deceased is necessary. If DEATH resulted from any form of violence, state the MEANS of injury, and whether ACCIDENTAL, SUICIDAL or HOMICIDAL. Statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25975

CERTIFICATE OF DEATH.

114 E 25975

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1021 McCulloh St 11-24 Ward)

2-FULL NAME Orcie Riley

(a) RESIDENCE NO. 1021 McCulloh St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1899

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) S. C.

PARENTS

10 NAME OF FATHER Orem Riley
11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. C.
12 MAIDEN NAME OF MOTHER Mack
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Interment Greenmount Cem
(Address) 1722 Eutaw Place

15 Filed 19
Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Bil-y Jaundice

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

19 27 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St George S.C. Date of Burial Sept 28 '27

20 UNDERTAKER Robert F Williams ADDRESS 1515 McElderry Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25976 — 90 E 25976

1-PLACE OF DEATH Hebrew Incurable Home — REGISTERED NO.

CITY OF BALTIMORE: (No. 2100 E. Balto. St. ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Forman

(a) RESIDENCE No. 216 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Sarah Forman

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Pressed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Forman (Address) 314 N. Fremont Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-29- 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 26 1927 to Sept 28 1927, that I last saw h(er) alive on Sept 28 1927, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

myocardial infarction

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL 9-29- 1927

20 UNDERTAKER Jacob Levin, 1439 E. — ADDRESS Balto. St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25977 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 E 25977

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 Mondawmin ave ST. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Barron

(a) RESIDENCE NO. 2319 Mondawmin ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah Barron

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 93; Months —; Days —; If LESS than 1 day, hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General

(b) General nature of industry, bnsiness, or establishment in which employed (or employer): Indse

(c) Name of employer: Merchant

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Aaron L. Barron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachael Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address): 1439 E Balto St

15 Filed, ... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/28 1927

17 I HEREBY CERTIFY, That I attended deceased from May, 1927, to Sept. 28, 1927, that I last saw h in alive on Sept. 28, 1927, and that death occurred, on the date stated above, at 6.59 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Sidney D. Levy M. D.

Sept. 29, 1927 (Address) 1124 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew — DATE OF BURIAL: 9/29 1927

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

25978

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 25978

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 6-9 Ward)

2-FULL NAME Baby (Girl) Buch

(a) RESIDENCE NO. 6123 Bath St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Girl	White	—

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-8-27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) Balt Md.

PARENTS

10 NAME OF FATHER Joseph Buch

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Levin

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Balto

14 Informant Hosp. Record

(Address)

15 Filed....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-28-27 19

17

I HEREBY CERTIFY, That I attended deceased from 9-8, 19 27, to 9-29, 19 27,

that I last saw h[illegible] alive on 9-29, 19 27,

and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Prematurity, Pyelitis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? .....Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Path

(Signed) Hugh Weintraub, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Mt. Carmel — Date of Burial: 9-29-1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1479 E. Balto. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

E

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH E 25979 — REGISTERED NO. E 25979

City of BALTIMORE: (No. 1336 N. Carey St., 15-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otis Smith

(a) RESIDENCE NO. 1336 N. Carey St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Smith

6 DATE OF BIRTH (month, day, and year) About Nov. 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	39	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Standard Sanitary Mfg Co

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Floyd Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Lula Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Hamilton Turner (Address) 1336 N. Carey St.

15 Filed....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ford degree burns of legs (Not fatal) while making bed pts. (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 10 ds.

(Signed) O. T. Hennessy M. D. (Coroner)

Sept. 27, 1927 (Address) 2512 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial Sept 29, 27.

20 UNDERTAKER Thomas E. Kelson ADDRESS 1303 Preston.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 25980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 25980

27-3

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 215-Club-Road St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Frances Laws

(a) RESIDENCE NO. 215-Club-Road. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. ? mos. ? ds. How long in U. S. if of foreign birth 69 yrs. 0 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David W. Laws

6 DATE OF BIRTH (month, day, and year) August-31-1858

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	69	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Middletown

(State or country) Penna

PARENTS

10 NAME OF FATHER William Starr

11 BIRTHPLACE OF FATHER (City or town) Middletown

(State or country) Penna

12 MAIDEN NAME OF MOTHER Katherine Holliday

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Emily L. Cross (daughter)

(Address) 215-Club-Road, Roland Park, City.

15 Filed ..... 19 .....

C. HAMPSON JONES

SEP 29 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927, to Sept 27, 1927, that I last saw h alive on Sept 27, 1927, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

Int Intestinal Metastasis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted V

If not at place of death?

Did an operation precede death? No Date of V

Was there an autopsy? Yes

What test confirmed diagnosis? V

(Signed) Lafferies Buck, M. D.

1927 (Address) No 5 Club Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Druid Ridge Cemetery	Sept-30-27
20 UNDERTAKER J. H. MOWEN COMPANY (William F. Mowen, Successor)	ADDRESS 1031 N. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT tion should be carefully supplied. AGE should be stated EXACTLY. P. OF DEATH in plain terms, so that it may be properly classified. Exact very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25981 ✓ E 25931 ✓

CERTIFICATE OF DEATH.

×129

1-PLACE OF DEATH St Agnes Hospital

City of BALTIMORE: (No. ____ St. 25-12 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Grove

(a) RESIDENCE NO. Marion Pa St. ____ Ward Marion-Pa.

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Grove

6 DATE OF BIRTH (month, day, and year): May-10-1859

7 AGE — Years: 68 — Months: — — Days: — — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town): Pa

(State or country): Pa

PARENTS

10 NAME OF FATHER: John Bittner

11 BIRTHPLACE OF FATHER (city or town): Penna

(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): Penna

(State or country)

14 Informant: Daughter - Blanche Grove

(Address) Marion Pa.

15 Filed ____, 19 ____ Per ____

SEP 29 1927 C. HAMPSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-29 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-14, 1927, to 9-29, 1927, that I last saw her alive on 9-29, 1927, and that death occurred, on the date stated above, at 7 15 a. m.

The CAUSE OF DEATH* was as follows:

Post Operative intestinal obstruction 9 days after removal of infected left tube and ovary

(duration) ____ yrs. ____ mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis - Chronic Nephritis

Chronic intestinal obstruction 3 weeks duration.

(duration) ? yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Marion, Pa.

Did an operation precede death? Yes Date of 9-20-27

Was there an autopsy? No

What test confirmed diagnosis? Microscopic study of tissues removed at operation.

(Signed) Joseph C Bloom, M. D.

, 19 (Address) 914 N. Chas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marion - Penna Date of Burial Sep 29 1927

20 UNDERTAKER: STEPHEN WOOLEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 25982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-001 E 25982

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 25-76 Ward)

2-FULL NAME Sarah Jenkins

(a) RESIDENCE NO. 232 9th St Fairfield Balto., Ward

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	Col	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Jenkins

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Alexander, Va.

PARENTS

10 NAME OF FATHER John unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Eliza unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Hospital Records
(Address)

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-intestinal hemorrhage
(Probably Typhoid Fever-Autopsy at Hopkins Hospital)

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. C. Hampson Jr. M. D.
(Coroner)

9/28/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Date of Burial Sept 29 1927

20 UNDERTAKER C. J. Brown & Son ADDRESS Baltimore

N. 23—WRITE PLAINLY, WITH UNFADING INK—THE tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 25983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-01

E 25983

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 141 W. Henrietta St. St. 22-31 Ward)

2-FULL NAME Collie Savage,(C)

(a) RESIDENCE NO. 141 W. Henrietta St. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. ____ mos. ____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	Colored	Married.

3a If married, widowed or divorced, HUSBAND of XXXXXXXXXXX Lena Savage.(C)

6 DATE OF BIRTH (month, day, and year) September 12, 1890.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER George Savage.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Sally Polston.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Hattie Weinberg.

(Address) 817 W. Mulberry St.

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 26, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bi-lateral Lobar Pneumonia.
Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. R. Reinhardt M. D.
(Coroner)

9/29 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem. Date of Burial 19

20 UNDERTAKER A. Wolfe & Son Funeral Dirs. ADDRESS Balto. Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-3-25—A Co.—200 Bks.

E 25984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 25984

1-PLACE OF DEATH

City of BALTIMORE: (No. 102 W. York St. St. 22-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Allen.(C)

(a) RESIDENCE NO. 102 W. York St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow.

5a If ~~XXXXX~~ widowed, ~~XXXXXXX~~ ~~XXXXXXXX~~ (or) WIFE of James Allen.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Canada.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Frank Allen.(C) son.

(Address) 102 W. York St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 28, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto R. Reinhardt M. D.
(Coroner)

9/29 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem. Date of Burial Oct. 3, 1927

20 UNDERTAKER C. F. Bowers & Son ADDRESS 15 N. Fulton Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Knepper

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25985

CERTIFICATE OF DEATH.

X 11 E 25985

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 5109 Lerchwood Ave ST.. 97-13 WARD

2-FULL NAME Elizabeth Knepper

(a) RESIDENCE. No. 5109 Lerchwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE: Lee Lon Knepper

6 DATE OF BIRTH (month, day, and year): Aug 30, 1852

7 AGE: Years 75 Months Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hunter Co Ky

PARENTS

10 NAME OF FATHER: Upton Cleary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ky

14 Informant: Clifford L. Knepper (Address): 5109 Lerchwood Ave.

15 Filed SEP 29 1927 19 Registrar RAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1927 to Sept 28, 1927, that I last saw her alive on Sept 28, 1927, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Appendicitis

Peritonitis (General)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Hypostatic Pneumonia, Edema of Lungs

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) W. E. Keyser M. D.

, 19 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Port Ky DATE OF BURIAL: Sept 29 27

20 UNDERTAKER: Harry H. Weitzel ADDRESS: 1531 W. Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M—500 Bks.

E 25986 Corday

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | E 25986

1-PLACE OF DEATH 703 Belgian ave

CITY OF BALTIMORE: (No.) 703 ST. 27-4 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Aurelia ~~Corday~~ (Corday)

(a) RESIDENCE NO. 703 Belgian ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Corday

6 DATE OF BIRTH (month, day, and year): 2/4/1900

7 AGE — Years: 27 Months: 7 Days: 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jos. Bretzinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Utica N. Y.

12 MAIDEN NAME OF MOTHER: Anna Feirty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Joseph Corday

(Address): 703 Belgian ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29, 1927

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1927, to Sept 29, 1927,

that I last saw h alive on Sept 29, 1927

and that death occurred, on the date stated above, at 1.30 p m

The CAUSE OF DEATH* was as follows:

Odema of Lungs

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bronchio - Pneumonia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. L. Lichtenberg, M. D.

9/29, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: 10/1 1927

20 UNDERTAKER: George & Ruth — ADDRESS: 1735 Hartford Ave

N. B.—WHITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M.

Spec.—1-12-23—M&T—500 Bks.

E 25987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO. E 25987

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 Boston ST. 1-1 WARD)

2-FULL NAME Julia Kawnacki

(a) RESIDENCE NO. 2314 Boston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Kawnacki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Rudnicki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Josephine Kawnacki
(Address) 2314 Boston St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1927 to Sept 28 1927, that I last saw her alive on Sept 28 19, and that death occurred, on the date stated above, at 730 Pm.

The CAUSE OF DEATH* was as follows:

Acute Flio - colitis
ca 4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank A Kennedy M. D.

(Address) 243 Fair

9/29/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary cem	Sep 30 1927
20 UNDERTAKER	**ADDRESS**
John M Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 44 E 25988

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ..... ST. ..... WARD)

2-FULL NAME George Hermiston

(a) RESIDENCE NO. Toronto, Ontario, Canada WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Helen M. Hermiston

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER William Hermiston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth Keough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Friend JOHNS HOPKINS HOSPITAL

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1927, to Sept. 29, 1927, that I last saw him alive on Sept. 29, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder
Prostate

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Osteosarcoma humerus

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Histology

(Signed) ..... M. D.

, 19 (Address) J. H. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Toronto Ontario Can. — DATE OF BURIAL 9/29 1927

20 UNDERTAKER H. H. Kretzler — ADDRESS 153 W. Lanvale

N. B.—WRITE PLAINLY, WITH CARBON INK. THE BLANKS MUST BE FILLED EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See Instructions on back of certificates.

Spec'l-7-17-26—A Co.—200 Bks.

E 25989

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25989

CERTIFICATE OF DEATH

57

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Greenfeld

(a) RESIDENCE NO. 247 N. Luzerne St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 52 — Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town)
(State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Russia

14 Informant: J. Lewis
(Address): 1439 E. Balto St.

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28/27

17 I HEREBY CERTIFY, That I attended deceased from 9/14/27, 19 , to 9/28/27, 19 , that I last saw h.e.r alive on 9/25/27, 19 , and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Diabetes and Gangrene of Left Foot & Leg 3 to 6 wks.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pa

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) F. S. Winstead, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Cemetery — Date of Burial: 9-29-1927

20 UNDERTAKER: Jos. Lewis — ADDRESS: 1439 E. Balto.

SEP 29 1927 C. HAMPSON JONES, M.D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 25990

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25990

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 264

City of BALTIMORE: (No. 21 Quick Avenue St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Franz

(a) RESIDENCE NO. 21 Quick Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 29th. 1927

7 AGE Years Months Days IF LESS than 1 day hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER: Edward Franz

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Elizabeth Mueller

13 BIRTHPLACE OF MOTHER (City or town): Balto. Md.

(State or country)

14 Informant: Mr. Edward Franz

(Address): 21 Quick Avenue

15 Filed SEP 29 1927 19 G. HAMPSON JONES, M. D. Registrar

Per Hand

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 29, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1927, to Sept. 29 1927.

that I last saw him alive on Sept. 29, 1927.

and that death occurred, on the date stated above, at 5:10 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth

8 months gestation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placental thrombosis of mother.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Prenatal examination

(Signed) Benj. D. Hamilton, M. D.

7/31 1927. (Address) 1216 N. Caroline

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial 9/29 19 27

20 UNDERTAKER: Chas. S. Evans & Son ADDRESS 1118 N. Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 86-09 2n- E 25991

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST. 9-17 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Voytmann
Sister Agnes

(a) RESIDENCE NO. 13 Raspeburg, Md ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15th 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	17	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Maryland

PARENTS
10 NAME OF FATHER John Voytmann
11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary Wolkoff
13 BIRTHPLACE OF MOTHER (city or town) Bremen (State or country) Germany

14 Informant John Voytmann
(Address) 6 Balto. Ave. Raspeburg

15 Filed ... 7 ... C. HAMPSON JONES M. D. 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1927. to Sept 27, 1927.
that I last saw her alive on Sept 25, 1927.
and that death occurred, on the date stated above, at 4.25 Pm.

The CAUSE OF DEATH* was as follows:
Sinus Thrombosis
Mastoiditis
Cerebral Abscess

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Tonsilitis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of Sept 27, 1927.
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) T. P. Thompson, M. D.
19 (Address) St. Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Lutheran Cemetery — DATE OF BURIAL: Oct 2 1927

20 UNDERTAKER: Frederick Lee Funeral Home — ADDRESS: Frederick

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25992

CERTIFICATE OF DEATH.

16 E 25992

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 N. Durham ST. 7-13 WARD)

2-FULL NAME Ruby Burns

(a) RESIDENCE NO. 915 N. Durham ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-2-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Manning Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pinckney S.C.

12 MAIDEN NAME OF MOTHER Lucinda Thompkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Danville Va.

14 Informant Mother

(Address)

15 Filed SEP 29 1927, 19 C. HAMPSON JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2-1927

17

I HEREBY CERTIFY, That I attended deceased from 9-2-1927, to 9-2-1927,

that I last saw h.. alive on 9-2-1927,

and that death occurred, on the date stated above, at 5:50 p. m.

The CAUSE OF DEATH* was as follows:

(a) Premature birth

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. Berry M. D.

, 19 (Address) 1530 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 29 1927

20 UNDERTAKER

ADDRESS Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 25993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 E 25993

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 N. Norris St. ST. 14-27 WARD)

2-FULL NAME Henretta Jennings Taylor

(a) RESIDENCE NO. 519 N. Norris St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Negro	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Peter Taylor

6 DATE OF BIRTH (month, day, and year) Aug. 20. 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	27	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Emory Jennings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Queen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jas. E. Washington
(Address) 517 N. Norris St.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27-1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27th. 19 27 to Sept. 27th. 1927

that I last saw her alive on Sept. 27th. 1927

and that death occurred, on the date stated above, at 12.45 m

The CAUSE OF DEATH* was as follows:

Epidemic Cerebrospinal Menimgitis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

. 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Sept 30, 19 27

20 UNDERTAKER R. Williams

ADDRESS 872 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

SEP 29 1927 C. HAMPSON JONES, M. D. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 25994

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

r/4-09 E 25994

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 419 E. 21st St.

(a) RESIDENCE NO. Dr. Thomas E. Lacy. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara D. Lacey.

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Govanstown Md

PARENTS

10 NAME OF FATHER John Lacey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Grimott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edward Lacey. (Address) 419 E. 21st Street

15 Filed ... 19 ... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1927, to Sept 28, 1927, that I last saw h[illegible] alive on Sept. 28, 1927, and that death occurred, on the date stated above, at 12 40 A m.

The CAUSE OF DEATH* was as follows:

Chr. Cholecystitis & Pancreatitis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-26-27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Lawrence Fahrney, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mem. Cathedral

DATE OF BURIAL Sept 29, 1927

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25995

CERTIFICATE OF DEATH

129 E 25995

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 25-77 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Szczepucha

(a) RESIDENCE NO. 28 Elm St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Magdalena Szczepucha

6 DATE OF BIRTH (month, day, and year): 5/8/1882

7 AGE — Years: 45 yrs. Months: 4 Days: 19

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Poland

PARENTS

10 NAME OF FATHER: Gaetan Szczepucha

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Wolkram

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland

14 Informant: Magdalena Szczepucha

(Address) 28 Elm St

15 Filed ..., 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 9/27/27

17 I HEREBY CERTIFY, That I attended deceased from 8/1/27, 19, to 9/27/27, 19, that I last saw h/im alive on 9/27/27, 19, and that death occurred, on the date stated above, at 10 45 a.m./p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary): Hypertrophic Arthritis

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 9/2/27 Date of 8/2/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. S. Winstead, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — Date of Burial: Sept 1927

20 UNDERTAKER: Hurd Funeral Co — ADDRESS: 1900 Orleans

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 29 1927

C. HUMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 25996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 25996

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No.) ST., 1-4 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary T. Lewis

(a) RESIDENCE NO. Aylett Va ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-13-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Augustine Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Blanch Vaun Sept 29, 1927

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Johns Hopkins Hospital (Address) Records

15 Filed ..., 19... Registrar

F. H. 1927 C. HAMPSON JONES, M. D.

RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1927, to Sept. 29, 1927, that I last saw her alive on Sept. 27, 1927 and that death occurred, on the date stated above, at 5.10 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor, brain stem, glioma, non malignant

(duration) 6 yrs. — mos — ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? yes Date of Sept. 28, 1927

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Warfield M Firor, M. D.

Sept 29, 1927 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va — DATE OF BURIAL 9/29/27

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25997

CERTIFICATE OF DEATH

129 E 25997

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2504 Garrison Blvd St. 15 61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane R. Martin

(a) RESIDENCE NO. 2504 Garrison Blvd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced: (write the word) Widow

5a If married, widowed, or divorced (or) WIFE of: Lawson L. Martin

6 DATE OF BIRTH (month, day, and year): July 17 1834

7 AGE. Years: 93 Months: 2 Days: 10 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Raughly N C

(State or country)

PARENTS

10 NAME OF FATHER David M Henning

11 BIRTHPLACE OF FATHER (City or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary A Hetzelberger

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md

(State or country)

14 Informant: G W Haddaway

(Address) 2504 Garrison Blvd

15 Filed ....., 19.....

Per APH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1927, to Sept 27, 1927.

that I last saw her alive on Sept 27, 1927.

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Dermatypic

(Signed) Wm Hand Cox, M. D.

(Address) 543 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore cemetery — Date of Burial 9/30 1927

20 UNDERTAKER: Robert Brookes Son — ADDRESS Calhoun Hollins Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

C. HAMPSON JONES M. D.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25998

CERTIFICATE OF DEATH.

E 25998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 717 Carlton St. Ward 21X)

2-FULL NAME Elias Richardson

(a) RESIDENCE NO. 717 Carlton St Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 20 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	—	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto City

(State or country)

PARENTS

10 NAME OF FATHER: Robt Richardson

11 BIRTHPLACE OF FATHER (city or town): D.C.

(State or country)

12 MAIDEN NAME OF MOTHER: Emma Gilliard

13 BIRTHPLACE OF MOTHER (city or town): D.C.

(State or country)

14 Informant: Robt Richardson

(Address) 717 Carlton St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held the (Inquest, autopsy or inquiry) thereon and from the evidence obtained [illegible] fied that said deceased came to [illegible] death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

Feb 29 1927 (Address) Curtis Bay Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial Feb 30 1927

20 UNDERTAKER: Daniel Easton ADDRESS 916 Paine

MARGIN RESERVED FOR [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 25999

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25999

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 N. Calhoun ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Dorsey

(a) RESIDENCE No. 920 N. Calhoun ST., ..WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C.	Married

5a If married, widowed, or divorced (or) WIFE of Emma Bell Dorsey

6 DATE OF BIRTH (month, day, and year) Oct 2-1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	22	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Drayer

(c) Name of employer Miller Produce

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Zachary Dorsey

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Md

12 MAIDEN NAME OF MOTHER Lula Pinckney

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Emma B Dorsey (Address) 920 N. Calhoun St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to Sept 27, 1927.

that I last saw h alive on Sept 26, 1927

and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos? ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 920 Calhoun St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Physical

(Signed) Wm. N. Wright, M. D.

(Address) 1209 Forrest ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Sept 30 27

20 UNDERTAKER Dennis Gordon ADDRESS 916 Pine

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 29 1927 C. HAMPSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26000

E 26000

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mw Hospital St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Gordon

(a) RESIDENCE NO. 802 Fisher (Fisher) St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colo	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of G. F. Gordon.

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) md

PARENTS

10 NAME OF FATHER Daniel Henderson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Mary Ellen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant G. F. Gordon

(Address) 802 Fisher St

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) C. L. Austin

(duration) ..... yrs. ..... mos. 1 ds.

Signed) C. L. Austin, M. D.

(Address) 1436 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brunswick Md Date of Burial July 29 1927

20 UNDERTAKER Harvey Easton ADDRESS Brunswick Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. M&T—500 Bks.

2942

E 26001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 E 26001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 N. Ellwood Ave ST.) (6-11 WARD)

2-FULL NAME Robert Melvin Breitenbach

(a) RESIDENCE No. 204 N. Ellwood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 15, 1925

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
2	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: August C. Breitenbach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Lena Reichardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: August Charles Breitenbach

(Address) 204 N. Ellwood Ave

15 Filed SEP 1927, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1927, to Sept. 28, 19—, that I last saw h— alive on Sept. 28, 19—, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute ~~Intestinal~~ Dia

Ileo Colitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Artigan, M. D.

, 19 (Address) 294 S Eaton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Oct. 1 1927

20 UNDERTAKER: Henry Sander & Sons Inc

ADDRESS: 1710 Fleet St.

C. HAMPSON JONES, M. D.

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26002 E 26002

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 E. Fort Ave. ST 23-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas C. Pancoast.

(a) RESIDENCE NO. 32 E. Fort Ave. ST, WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 11 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT ACCORDING TO INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Levinia Pancoast.

6 DATE OF BIRTH (month, day, and year) Oct, 8, 1845.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	81,	11,	21.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Poultry Dealer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dont Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Clara Cain.

(Address) 32 E. Fort Ave.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 29 1927.

17

I HEREBY CERTIFY, That I attended deceased from May 21, 1927 to September 29, 1927.

that I last saw him alive on September 29, 1927.

and that death occurred, on the date stated above, at 245 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterial Hypertension

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Albert C. Cain M. D.

9/29, 1927. (Address) 2025 E North Ave

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Oct 3 1927

20 UNDERTAKER C. Edmund Evans & Co.

ADDRESS

C. HAMPSON JONES, M. D.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E-26003

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26003

CERTIFICATE OF DEATH.

161-001

E 26003

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2206 Aiken St. 9-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Allen Jr

(a) RESIDENCE. No. 2206 Aiken St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed or Divorced (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15/27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: ~~Bessie Sinclair~~ Lisa Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): John Allen 2206 Aiken

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1927, to Sept 29, 1927, that I last saw him alive on Sept 29, 1927 and that death occurred, on the date stated above, at 3-30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth
about 6 mo. foetal month

(duration): yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. H. Pearce, M. D.

Sept 29 1927 (Address) 2105 St. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Sept 30 1927

UNDERTAKER: W. Cook

ADDRESS: 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.P.B.S.—400 Bks.

E 26004

E. 26004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 26004

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 249 N Bruce St. 9-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Henry

(a) Residence No. 249 Bruce St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem'l 4-COLOR OR RACE, Colored 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Henry

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer. None Reported

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Perry Grant

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Mary Hopper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Bennetta Address 249 N Bruce St

15- Filed SEP 30 1927 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 27-27

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1927 to Sept 27 1927 that I last saw her alive on Sept 27 1927 and that death occurred, on the date stated above, at 3-15 P m.

The CAUSE OF DEATH was as follows:

Nephritis

(Duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Attending Dr

(Signed) John E Stewart, M. D.

, 19 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary DATE OF BURIAL, 9-30 1927

20-UNDERTAKER Joseph A Libely ADDRESS 409 N Mount st

N. B.—WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E26005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

Registered No. E 26005

1-PLACE OF DEATH

City of BALTIMORE: (No. 4117 E. Franklin Ave St. 27-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Pentland Lenhoff

(a) Residence No. 4117 E. Franklin Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced ~~HUSBAND of~~ WIFE of: Jos. H. Lenhoff

6-DATE OF BIRTH (month, day and year): June 4 1875

7-AGE: 52 yrs. 3 mos. 24 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS

10-NAME OF FATHER: John G Hollmeyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Susanne ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant) Joseph H Lenhoff

(Address) 4117 E Franklin Ave

15- Filed, 19 Registrar.

SEP 30 1927 BALTIMORE MD

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept 28 1927

17- I HEREBY CERTIFY, That I attended deceased from July 12 1927 to Sept 28 1927 that I last saw h[illegible] alive on Sept. 24 1927 and that death occurred, on the date stated above, at 2:05 P m.

The CAUSE OF DEATH* was as follows:

Primal abdominal Cancer
(Adeno-Carcinoma)

over

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Intestines and Appendix

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 12/27

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic Biopsy Tissue

(Signed) William A Gordon, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Sept 1, 1927

20-UNDERTAKER: Leonard J Ruck

ADDRESS: Lyttanave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Saunders

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26006

CERTIFICATE OF DEATH.

159-002

E 26006

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 S Montgomery ST. 22-33 WARD)

2-FULL NAME Otis M Saunders

(a) RESIDENCE NO. 116 S Montgomery ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9 /27

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
				1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Otis M Saunders

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Hannie Nash

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant Otis M Saunders
(Address) 116 S Montgomery

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29/27

17

I HEREBY CERTIFY, That I attended deceased from Sept 29/27 19 , to Sept 29/27 19 .

that I last saw h[illegible] alive on Sept 29/27 19 ,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Blue Body
Defective Circulatory System
(duration) ..... yrs. ..... mos. 7 hrs ds.

CONTRIBUTORY (Secondary) not known
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood

(Signed) Thos B Kelly M. D.

Sept 29, 19 27 (Address) 1 W Eight

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newland Va — DATE OF BURIAL Sept 30 1927

20 UNDERTAKER John F Denny — ADDRESS 715 Lis[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr. W. Jackson.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26007

E 26007

CERTIFICATE OF DEATH.

175

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 929 Sheilds Place St., 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Brown

(a) Residence No. 929 Sheilds Place St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, Divorced (write which)
Male	Col	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1907

7-AGE 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Mabell McClendon

(Address) 929 Sheilds Place

15- Filed ..... 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 27. 27

17- I HEREBY CERTIFY, That I attended deceased from Sept. 27th. 1927 to Sept. 27th. 1927

that I last saw h. 1m alive on Sept. 27 19 27

and that death occurred, on the date stated above, at 11;30 a.m.

The CAUSE OF DEATH* was as follows:

Ptomain Poisoning (Canned Sardines)

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Hist. & Exam.

(Signed) Walter J. Jackson M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL North West Va

DATE OF BURIAL Sept. 30. 1927

20-UNDERTAKER Hamet Forbes

ADDRESS 416 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

26008

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

54 E 26008

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 22-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Craig (Newton)

(a) RESIDENCE NO. 113 St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington

(State or country) D. C.

PARENTS

10 NAME OF FATHER Addison Newton

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Belle ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant

(Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 .....

Registrar

SEP 30 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27/ 1927

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1927 to Sept. 27, 1927 that I last saw h e alive on Sept. 27, 1927 and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra.

Vincents angina

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? ? Date of

Was there an autopsy? No

What test confirmed diagnosis? Smear & Culture

(Signed) C. Holmes Bryd, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery — Date of Burial Sept 30 1927

20 UNDERTAKER Edward Bryan — ADDRESS 1691 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 2-26-27 200 Bks.

E 26009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001
E 26009

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1526 Hollins St., 14-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Fortenbaugh

(a) RESIDENCE NO. 1526 Hollins St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Fortenbaugh

6 DATE OF BIRTH (month, day, and year): May 30, 1865

7 AGE — Years: 62 Months: 3 Days: 29

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Alexandria

(State or country): Va

PARENTS

10 NAME OF FATHER: Frederick Raab

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Appich

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Alexandria Va

14 Informant: Charles D. Fortenbaugh

(Address) 1526 Hollins St

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 28 Sept. 1927

17

I HEREBY CERTIFY, That I attended deceased from 20 Aug, 1927, to 28 Sept. 1927,

that I last saw h[illegible] alive on Sept 28, 1927,

and that death occurred, on the date stated above, at 2 0 [illegible] m.

The CAUSE OF DEATH* was as follows:

Coronal apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cystitis chronic

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death? V

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? non

(Signed) [illegible], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Oct 1 1927

20 UNDERTAKER: George A. Smith — ADDRESS 1581 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor. 12-8-26 M&G—200 Bks.

E 26010

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Home for the Aged Fulton ave - methodist ..... St., ... Ward)

REGISTERED NO. E 26010

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Mason

(a) RESIDENCE NO. 400 N. Fulton Ave ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 Color or Race: White — 5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr 16th 1856

7 AGE: Years 71 Months 5 Days 12 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Patrick Moran

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Louisiana Pratt

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Etta Purdy (Address) Methodist Home for Aged

15 Filed ....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained ... find that said deceased came to ... death on the day stated above. (autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Sept 29 1927 (Signed) Thos. B. Horton M. D. (Coroner) (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem. Date of Burial: Sept 30 1927

20 UNDERTAKER: George J. Smith ADDRESS 1534 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form 1927 M&L 1250 Blks.

E 26011

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 9E 26011

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4010 Ridgewood Ave ST., 15-66 WARD)

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Emory Hoffman

(a) RESIDENCE NO. 4010 Ridgewood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. G. Hoffman

6 DATE OF BIRTH (month, day, and year) Oct. 7 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	84	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Paper Mfg

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. E. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa

12 MAIDEN NAME OF MOTHER Margaret Brand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Wm C. V. Hoffman

(Address) 4010 N. Ridgewood Ave

15 Filed . 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Sept 27, 1927, that I last saw he alive on Sept 27, 1927 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chronic Interstitial nephritis, Hypertrophied Prostate, Chronic Myocarditis, Emphysema

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William G. Lamm M. D.

9/28, 1927 (Address) 350 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Druid Ridge Sept 30 1927

20 UNDERTAKER — ADDRESS

Chas E. Franck 307 Madison

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26012

CERTIFICATE OF DEATH.

E 26012
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 25-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ryan

(a) RESIDENCE NO. Round Bay. Annapolis Blvd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Julia Ryan

6 DATE OF BIRTH (month, day, and year): Feb 5 1854

7 AGE: Years 74 | Months 7 | Days 24 | If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Oil Business
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Maryland

PARENTS

10 NAME OF FATHER: John Ryan

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Nolan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Ireland

14 Informant
(Address): Julia Ryan Round Bay - Annapolis Blvd

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-29 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-29 1927 to 9-29 1927, that I last saw him alive on 9-29 1927, and that death occurred, on the date stated above, at 11 12 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary): Myocarditis

(duration) yrs. mos. ds.

If Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirm diagnosis?

(Signed) Francis Di Padoglia M. D.

19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial 10/1/1927

20 UNDERTAKER: Chas R. Raue & Son ADDRESS: 11 W Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—MAT—500 Bks.

Spec.—1-12-23—MAT—500 Bks.

E 26013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26013

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secour Hospital ST. (WARD) 67

2-FULL NAME Louis D. Starr

(a) RESIDENCE NO. 1523 N. Eutaw St. WARD
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anne Bauer Starr

6 DATE OF BIRTH (month, day, and year): Mar 28-1883

7 AGE: Years 44 | Months 6 | Days — | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Asst Purchasing Agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Standard Oil

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: Edward V. Starr
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md
12 MAIDEN NAME OF MOTHER: Alice France
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Anne Bauer Starr 1523 N. Eutaw St

15 Filed , 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28- 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1927, to Sept. 28, 1927, that I last saw h im alive on Sept 28, 1927, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:
Acute Appendicitis
Localized Peritonitis
(duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary) Intestinal obstruction
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? Yes Date of Sept 19/27
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical + Autopsy
(Signed) George O. Eaton, M. D.
, 19 (Address) Bon Secour Hosp l.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Oct 1st 1927

20 UNDERTAKER: Chas P. Crane & Son — ADDRESS: 1152 N Royal Ave

N. B.—WRITE PLAINLY, with pencil. AGE should be carefully supplied. mation should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that i TION is very important. See instructions on

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26014
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

117 E 26014
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. Sinai Hospital St., 6-9 Ward)

2-FULL NAME Phillip Cohen

(a) RESIDENCE NO. 23 N Ann St St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 4 mos. 14 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May. 5-1925

7 AGE — Years: 2 — Months: 4 — Days: 14 — If LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Ben Cohen

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Hetta Edansky

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

11 Interment L. Lewis
(Address)

15 Filed ..... 19 H. Adams

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-29-27 19

17 I HEREBY CERTIFY, That I attended deceased from 9-28 19 27, to 9-29 19 27,
that I last saw him alive on 9-29 19 27
and that death occurred, on the date stated above, at 7 10 P m.

The CAUSE OF DEATH* was as follows:
Acute Appendicitis
Acute Peritonitis

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted
If not at place of Death!
Did an operation precede death? Yes Date of 9 29 27
Was there an autopsy? Yes
What test confirmed diagnosis?

(Signed) Harry Weinberg, M. D.
19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Hebrew Rosedale 9 30 19 27

20 UNDERTAKER — ADDRESS
Jack Lewis 1434 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

12-9-25 A.C.

E 26015 — E 26015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 34

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2026 E. Hoffman St. 9-17 Ward)

2-FULL NAME Julia D. Hilditch

(a) RESIDENCE NO. 2026 E. Hoffman Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Archer B. Hilditch

6 DATE OF BIRTH (month, day, and year): Aug. 8 - 1904

7 AGE — Years: 23 — Months: 1 — Days: 1 — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: James Shabek

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Julia Cronin

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Mr. Hilditch

(Address): 2026 E. Hoffman

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 29 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4 1927 to Sept. 29, 1927 that I last saw her alive on Sept 25, 1927 and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 6 mos. ago

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) Chas. E. Simpson Ald, M. D.

9/28/1927 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial 10/ 1927

20 UNDERTAKER: J. Fen McCully — ADDRESS 130 E. Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of this information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 26016

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26016

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 2756 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry E. Scherf

(a) RESIDENCE NO. 4620 Park Heights Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Myers Scherf

6 DATE OF BIRTH (month, day, and year) Nov 13 75

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D C

(State or country)

PARENTS

10 NAME OF FATHER Henry Scherf

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mamie M Scherf

(Address) 4620 Park Heights

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Heuisler, M. D.

(Coroner)

Sept 29 1927 (Address) 2577 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Oct 1 1927

20 UNDERTAKER W M Monteon ADDRESS 223 N Mt St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 26017 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 26017

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospitals St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kirby

(a) RESIDENCE NO. 2204 Rushmore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 14-1864

7 AGE: Years 62 Months 9 Days 14 IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: James B. Kirby

11 BIRTHPLACE OF FATHER (City or town): Maryland

(State or country)

12 MAIDEN NAME OF MOTHER: Julia Gannon

13 BIRTHPLACE OF MOTHER (City or town): Md.

(State or country)

14 Informant: Mrs Jas L. Haddaway

(Address): 2426 Woodbrook

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Sept. 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1927 to Sept 28, 1927

that I last saw him alive on Sept 28, 1927

and that death occurred, on the date stated above, at 6.28 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Duration

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. B. Kinyoun M. D.

(Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL: Md. Leighmans Island Date of Burial Oct 1 19 27

20 UNDERTAKER: Wm Tuckers Sons ADDRESS N. Y. Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

SEP 30 1927

Pat

Cor.—12-9-25—A Co.—200 Bks.

0276018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 0276018

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 26-27 Ward)

2-FULL NAME Ruth Thompson

(a) RESIDENCE NO. Boot Run Rd St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 7

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Thompson

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: Years: About 34 Months: _____ Days: _____ IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer): _____

(c) Name of employer: _____

9 BIRTHPLACE (city or town): _____

(State or country): Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Not Known

12 MAIDEN NAME OF MOTHER: Sarah Roberts

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Md

14 Informant: E. V. Dyer

(Address): Frederick, Md.

15 Filed.....19..... _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Alcoholism

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

Signed) G. C. Gadd, M. D.

(Coroner)

(Address) 143 W. Patrick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick, Md Date of Burial: Oct 29 1927

20 UNDERTAKER: M. R. Etchison & Son ADDRESS: Frederick, Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 26019 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26019

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2909 (St.) Baker (Ward) 15-67

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Eggers

(a) RESIDENCE. No. 2909 St., Baker Ward.

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry A Eggers

6 DATE OF BIRTH (month, day, and year) Feb 25 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Reinhardt Ruppel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Eliz Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Carrie Fentz.

(Address) 2909 Baker St

15 Filed ..... 19.....

Registrar

C. HAMPSON JONES, M.D.

SEP 30 1927

Dec.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 ..... 19 27 . to Sept 28 . 19 27 .

that I last saw h-r alive on Sept 28 . 19 27 .

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBITORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H G Jones, M. D.

29, 192 (Address) 720 St North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	10-1 1927

20 UNDERTAKER Mrs Chas A G Rohde ADDRESS 2327 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26020

CERTIFICATE OF DEATH.

E 26020

REGISTERED NO. 162

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 522 N Mount St. (9-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Medum

(a) RESIDENCE. No. 522 N Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) Sept 7, 77

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3 day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Samuel Medum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Maggie Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Samuel Medum
(Address) 522 N Mount St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 28 1927, to Sept 28 1927, that I last saw h— alive on Sept 29 1927, and that death occurred, on the date stated above, at 10 pm m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bleeding intestines

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Sept 30, 1927 (Address) 10 Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	9-30 1927

20 UNDERTAKER Joseph A Sudy ADDRESS 401 N Mount st

OCT 30 1927 C. HAMPSON JONES

Health

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 26021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 26021

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital 28-11 St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Nitsch

(a) RESIDENCE NO. Athol Terrace St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	8	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas. F. Nitsch
11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Germany
12 MAIDEN NAME OF MOTHER Josephine Fuerst
13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Germany

14 Informant Dr P. C. Nitsch
(Address) Athol Terrace

15 Filed _____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-30-1927

17 I HEREBY CERTIFY, That I attended deceased from 9-26-, 1927, to 9-30-, 1927, that I last saw him alive on 9-30, 1927, and that death occurred, on the date stated above, at 10.45 a m.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma of Thyroid (duration) yrs. 18 mos. ____ ds.

CONTRIBUTORY (Secondary) Oedema of Glottis (duration) ____ yrs. ____ mos. 7 ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 29, 1927

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. L. Desaglioca M. D.

9/30/1927 (Address) St Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Date of Burial Oct 1 1927

20 UNDERTAKER [illegible] ADDRESS [illegible]

N. B.—WRITE PLAINLY, with pen and ink—and do not use lead pencil. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

P. C. HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Blks.

Quilling ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26022

CERTIFICATE OF DEATH.

118-002

E 26022

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 16 St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Quilling

(a) RESIDENCE NO. 522 N. Schroeder ST. WARD a

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. WITH LEAD PENCIL. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Quilling

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 78 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mr. Hood

(Address) 723 Granby

15 Filed ., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): SEPTEMBER 28 1927

17

I HEREBY CERTIFY, That I attended deceased from September 15, 1927, to September 28, 1927, that I last saw her alive on September 28, 1927, and that death occurred, on the date stated above, at 4:10 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction, Volvulus

(duration) — yrs. — mos. 16 ds.

CONTRIBUTORY (Secondary): Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 522 N. Schroeder St.

Did an operation precede death? Yes Date of Sept. 15, 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) W. Wallace Miller M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Oct 30 1927

20 UNDERTAKER: John J. Fields — ADDRESS: 1200 W. Fayette

SEP 30 1927 C. HAMPSON JONES, M.D.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E ~~26023~~ E 26023

1-PLACE OF DEATH

~~E 26023~~ E 26023

REGISTERED NO. 90 E 26023

City of BALTIMORE: (No. 2922 Elliott St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalena Chaja

(a) RESIDENCE NO. 2922 Elliott St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 60 Months 5 Days

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Poland

(State or country)

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (City or town): Poland

(State or country)

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town): Poland

(State or country)

14 Informant: Amelia Boecko

(Address) 2922 Elliott St

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 19 27 to to Sept 28 19 27

that I last saw her alive on Sept 26, 19 27

and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Sellers, M. D.

9-29, 19 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem

Date of Burial: Oct 1 19 27

20 UNDERTAKER: Stephen Galbraith

ADDRESS: 1700 Aliceanna St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Any death not reported within ten days after occurrence is subject to a penalty. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 30 1927 C. CHAMPION JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

E 26024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

202 ✓ E 26024

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Agnes Hosp'l (St.) (Ward)

2-FULL NAME Thomas Challoner

(a) RESIDENCE NO. 1016 N. Fulton ave (St.) Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marcella E. Challoner

6 DATE OF BIRTH (month, day, and year): June 8th 1853

7 AGE — Years: 74. Months: 8 Days: 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mead Jobber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town):

(State or country): England

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Mary Taylor

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): England

14 Informant: Mrs M. Reid Scott

(Address): 1600 Park ave

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH: (month, day and year) Sept 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained at said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull & Intra Cranial Hemorrhage

Accidentally Knocked down by Col'd Man unknown — running away from Police

Signed Thos. B. Horton M. D.

(Coroner)

Sept 29 1927 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: 10/1/1927

20 UNDERTAKER: Ger. Weber — ADDRESS: 2503 Edmondson

If the death occurred in a hospital or institution, the NAME and LOCATION should be stated EXACTLY. PHYSICIANS should be careful to see that CAUSE OF DEATH is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26025 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26025

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 13 Filbert St., 25-17 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Minarik

(a) Residence No. 13 Filbert St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 24-1927

7-AGE. yrs. mos. ds. If LESS than 1 day, 3 hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country). Curtis Bay Md

PARENTS.

10-NAME OF FATHER. Joseph Zajmarik

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Rosa Zamorsky

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

14- (Informant) Joseph Zamorsky

(Address) 13 Filbert

15-

Filed 19?

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1927 to Sept 29 1927

that I last saw him alive on Sept 29 1927

and that death occurred, on the date stated above, at 8.45 P. M.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum Stillbirth
Premature Birth 5 mos.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. J. Horn M. D.

Sept 30 1927 Address Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross DATE OF BURIAL. Sept 30 1927

20-UNDERTAKER. Frank Crockett ADDRESS 1906 Eutaw

Please be careful to answer all questions in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Blks.

E 26026

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26026

CERTIFICATE OF DEATH

46

1-PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO. 17-23

City of BALTIMORE: (No. ____ St. ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tomlinson or Thompson

(a) RESIDENCE NO. 703 St. Fremont St. Ward ____
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE: Years 63 Months Days

IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) ____ (State or country) S. C.

PARENTS

10 NAME OF FATHER Frank Stanley

11 BIRTHPLACE OF FATHER (City or town) ____ (State or country) S C.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) ____ (State or country) S C.

14 Informant Minnie Walker

(Address) 703 Fremont ave

15 Filed ____ 19 ____ Registrar ____

SEP 30 1927 C. HAMPSON JOHNSTON

Per ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/26/27, 19____, to 9/28, 1927, that I last saw h[illegible] alive on 9/28, 1927, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Cervix

Uterus (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Uremic Toxemia

(duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted Uterus

if not at place of death? ____

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) R. W. Hack, M. D.

, 19 (Address) Balt City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Oct 2. 1927 — Date of Burial

20 UNDERTAKER: Lottie Gross — ADDRESS: 1405 Mcelderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Physicians should be careful in filling out the cause of death. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 26027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 26027

REGISTERED NO. 96-37

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Green

(a) RESIDENCE NO. Reedville, W. C. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE — Years: 33 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Latham Green

11 BIRTHPLACE OF FATHER (City or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Smith ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant

(Address) Reedville

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27/1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24 1927, to Sept. 27, 1927

that I last saw h. alive on Sept. 27, 1927.

and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Alcoholism, acute

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General appearance

(Signed) C. Strickland Berry, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

20 UNDERTAKER — ADDRESS

BALTIMORE CITY HOSPITALS — UNIVERSITY OF MARYLAND

C. HAMPSON JONES, M. D. — Commissioner of Health

SEP 30 1927

SEP 30 1927

N. B.—PRIME PARENT, WIFE OR HUSBAND should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 26028

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26028

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Raynor

(a) RESIDENCE NO. 1121 E. [illegible] ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1927

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

One

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER George Raynor

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Fannie Askew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant O'Neill Wickham M.d

(Address) Johns Hopkins Hospital

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1927

17

I HEREBY CERTIFY, That I attended deceased from 9-23, 1927, to 9-24, 1927,

that I last saw him alive on 9-24 1927

and that death occurred, on the date stated above, at 5-00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) O'Neill Wickham M. D.

9-29, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER (Name) Board of Health

ADDRESS SEP 30 1927

mation should be carefully supplied. AGE should be stated EXACTLY. Illegible CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

33

30 1927

1750 ARM

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26029

CERTIFICATE OF DEATH.

40 E 26029

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1307 Park Ave ST. 11-24 (WARD)

2-FULL NAME Rachel Estep Shackelford

(a) RESIDENCE NO. 1307 Park Ave ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of W. T. Shackelford

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 63 | Months 7 | Days | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West River Co. A. Co. Md

PARENTS

10 NAME OF FATHER: Richard T Shackelford

11 BIRTHPLACE OF FATHER (city or town) (State or country): West River A. A. Co Md

12 MAIDEN NAME OF MOTHER: E. Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West River A. A. Co Md

14 Informant: W. T. Shackelford
(Address): 1307 Park Ave

15 Filed ..., 19 ... Registrar ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1926, to Sept 29, 1927, that I last saw h~~er~~ alive on Sept 29, 1927 and that death occurred, on the date stated above, at 10.30 P m

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Valvulitis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed): Charles McCeley, M. D.

, 19 (Address) 1609 London Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Oct 1st 1927

20 UNDERTAKER: Percy H Jenkins — ADDRESS: Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement must be filled in. See instructions on back of certificates. ATTENTION is very important.

Spec.—7-17-26—A Co.—200 Bks.

E 26030

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26030

CERTIFICATE OF DEATH

161-60

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3605 Sycamore St 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Foetus Shipley

(a) RESIDENCE NO. 3605 Sycamore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Foetus

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day 1 hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Foetus

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Benner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) New York, N.Y.

12 MAIDEN NAME OF MOTHER Evelyn Shipley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto, Md.

14 Informant Mrs. Wm. Shipley

(Address) 3605 Sycamore St

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Sept. 29

17

I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1927, to Sept. 29, 1927, that I last saw her alive on Sept 29, 1927 and that death occurred, on the date stated above, at 1:45 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Martin, M. D.

. 19 (Address) 4037 Falls Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial Oct 1 1927

20 UNDERTAKER E. L. Roy Stafflee ADDRESS 1258 North ave

N. B.—NAME, PARENTS, BIRTHPLACE, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 30 1927 C. HAMPSON JONES, M. D. Registrar

Dft

Cor.—12-9-25—A Co.—200 Bks.

E 26031

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26031

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1143 N. Hamburg St., 21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis J. Creamer

(a) RESIDENCE NO. 1143 N. Hamburg St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 18 = 1908

7 AGE: Years 18 Months 9 Days 10

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: John Creamer

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 NAME OF MOTHER: Catherine Creamer

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: John Creamer

(Address): 1143 N. Hamburg St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 28 = 1927

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest (or autopsy or inquiry.) thereon and from the evidence obtained [illegible] find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Merton M. D.

(Coroner)

Sept 30 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Date of Burial Oct 1 1927

20 UNDERTAKER: Mrs Mrs. John W. Templeton ADDRESS 801 W. C

tion should be carefully supplied. AGE should be stated E. G. HEALTH. PHYSICIANS should sign OF DEATH b. plain terms, so that it may be properly very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26032

CERTIFICATE OF DEATH.

90 E 26032

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 E Preston ST. 8-12 WARD)

2-FULL NAME Mary Louise Bowen

(a) RESIDENCE NO. 2105 E Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane L. Bowen

6 DATE OF BIRTH (month, day, and year) Aug 8 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Rehberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Lulu E. Bowen (Address) 2105 E Preston St

15 Filed Sept 29 19 27 Registrar ARM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 1927 to Sept 28 1927, that I last saw her alive on Sept 28 1927, and that death occurred, on the date stated above, at 2.35 P m.

The CAUSE OF DEATH* was as follows: Cardiac Stenosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. Dillman M. D.

Sept 29 19 27 (Address) 1839 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Oct 1 1927

20 UNDERTAKER: Henry Lutz — ADDRESS 1263 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 26033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26033

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. T. Justice

(a) RESIDENCE NO. Cooksville, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 22 = 1922

7 AGE: Years 5 Months 2 Days 7

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ck

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Howard Co.

(State or country) Md

PARENTS

10 NAME OF FATHER Wm. M. Justice

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Esterday

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant William M. Justice

(Address) Cooksville, Md

15 Filed ....., 19 .....

Pa: ACS Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 - 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation and autopsy (or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Auto Accident 10 hrs

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Signed) Thos. B. Horton M. D.

(Coroner)

(Address) Curtis Bay

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: McKendree Howard Co. Md

Date of Burial: Oct 1 1927

20 UNDERTAKER: J. M. Cook

ADDRESS 502 N. Howard St

tion should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 26034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26034

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 E Pratt St ST. 35 (Known as WARD) (McKenny)

2-FULL NAME Joseph Nicholas Mechetti

(a) RESIDENCE NO. 1503 E Pratt St ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ida. Mechetti.

6 DATE OF BIRTH (month, day, and year) March 19, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Cab

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Mechetti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Millanovo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Ida Mechetti (Address) 1503 E Pratt St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 28, 1927, to Sept 30, 1927, that I last saw him alive on Sept 29, 1927, and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Larynx

(duration) yrs. 2 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 801 S Lakewood

Did an operation precede death? Yes Date of 8/12/27

Was there an autopsy? No.

What test confirmed diagnosis? Path. Studies Mercy Hosp.

(Signed) Thos. F. A. Simms, M. D.

9/30/1927 (Address) 2818 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 10/3 1927

20 UNDERTAKER W. M. Cook — ADDRESS 502 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Trought) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26035

E 26035

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 S Popplelon St. (Ward) 18-24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter S Trought

(a) RESIDENCE NO. 111 S Popplelon ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie R Trought

6 DATE OF BIRTH (month, day, and year) 1-7-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) United 07&

(c) Name of employer Railways. Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Trought

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Annie R Trought

(Address) 111 S Popplelon

15 Filed , 19 APH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1927

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to Sept 30, 1927,

that I last saw him alive on Sept 30, 1927

and that death occurred, on the date stated above, at 1 40 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W W Brydon, M. D.

9/30, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon park Cem

DATE OF BURIAL Oct 3 1927

20 UNDERTAKER W W Cook

ADDRESS 502 E North ave

mation should be carefully supplied. Exact statement of OCCUPA-
it may be properly classified.
CAUSE OF DEATH in plain terms, so that it m
on back of certificates.
TION is very important: See instructions on b

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26036

CERTIFICATE OF DEATH.

E 26036

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3102 Baker St. 16-67 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Pfeiffer

(a) RESIDENCE NO. 3102 Baker St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Katie Pfeiffer

6 DATE OF BIRTH (month, day, and year) July 12 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	52	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Geo. E. Harris

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Nicholas Pfeiffer

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Snyder

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Katie Pfeiffer
(Address) 3102 Baker St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 28th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 1927 to Sept 27 1927 that I last saw him alive on Sept 27 1927 and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Don't Know (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Goodrich, M. D.

9-30 1927 (Address) 107 W. Seventy St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Oct 1st 1927

20 UNDERTAKER F. B. Kufpfert. — ADDRESS 1850 N. Gallo St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26037

CERTIFICATE OF DEATH.

114

E 26037

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Ave St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wayman Taylor

(a) RESIDENCE NO. 753 Dolphin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1904

7 AGE: Years about 23 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs Johnson

(Address) 924 Lemmon ave

15 Filed 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute Dil. of heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) acute Gastro enteritis

(duration) yrs. mos. 1 ds.

(Signed) A. T. Hamman M. D.

(Coroner)

Sept. 29 27 (Address) 2512 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leeds Va Date of Burial: Sept 30 1927

20 UNDERTAKER: Dent Easton ADDRESS 916 Pa ave

tion should be carefully supplied. Age should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26038

E 26038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Pronounced dead at the 1-3

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Heinze.

(a) RESIDENCE NO. 832 S. Milton Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 1 mos. 21 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White.	Widower.

5a If ~~married, widowed,~~ ~~divorced~~ WIFE or HUSBAND of ~~XXXXXXXXXX~~ Margaret Heinze.

6 DATE OF BIRTH (month, day, and year) August 7, 1872.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	55	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Eastern Transportation

(c) Name of employer: Company.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: August Heinze.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary Scherer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Marion Heinze.(son)

(Address): 832 S. Milton Ave.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 28, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

(Coroner)

9/30 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Davison Chemical Co. Curtis Bay 9/28/27

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — Date of Burial: Oct. 1 1927

20 UNDERTAKER: Henry Sonder & Sons Inc — ADDRESS: 1710 Fleet St.

Red

tion should be carefully supplied. Age should be given in years, months and days. Cause of death must be properly classified. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26039

CERTIFICATE OF DEATH.

E 26039

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3000 Baker - ST. 16-67 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Bauer Smith.

(a) RESIDENCE. No. 3000 Baker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? —— yrs. —— mos. —— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ WIFE of: William L. Smith

6 DATE OF BIRTH (month, day, and year): Apl. 15-1860

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
67	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Frank Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Schrine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): William L. Smith, 3000 Baker St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 30 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1927, to Sept. 30, 1927, that I last saw h[illegible] alive on Sept. 30, 1927, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

Indefinite. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Indefinite.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No chemical and microscopic analysis

What test confirmed diagnosis?

(Signed) Harry N. Arthur M. D.

Sept 30 1927 (Address) 3908 Hillsdale Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct. 3 — 1927
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E. Eager St.

MAKE STATEMENTS BRIEF, but in plain terms, so that it may be properly classified. Each statement CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26040

CERTIFICATE OF DEATH

161-001

E 26040

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1504 N. Spring St. 9-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Preisinger

(a) RESIDENCE NO. 1504 N. Spring St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Male

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): September 30 1927

7 AGE Years Months Days IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John. H Preisinger

11 BIRTHPLACE OF FATHER (City or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Edna Voelkerding

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs John Preisinger
(Address) 1504 N. Spring Ave

15 Filed ..., 19... R M Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 19 27, to Sept 30, 19 27,

that I last saw h... alive on ..., 19...,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur J. Hyson M. D.

(Address) 504 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Oct 1 1927

20 UNDERTAKER: Henry Houck Son — ADDRESS: 1801 E Eager St

tion should be carefully supplied. AGE should be stated EXACTLY. ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26041

1-PLACE OF DEATH

CERTIFICATE OF DEATH

× 66

E 26041

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS Street 7-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Clay Bowles

(a) RESIDENCE NO. 2 Adam, Jr. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ? ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	5	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Bowles

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Indiana

14 Informant BALTIMORE CITY HOSPITALS

(Address) Various.

15 Filed ..., 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1927 to Sept 29, 1927

that I last saw him alive on Sept 29, 1927

and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Alcoholism, acute

Anemia

Alcoholic paraplegia

(duration) ... yrs. 1 mos. ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Sub

(Signed) C. Wellington Bowles M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Crownd Hill Cemetery	Oct 1 1927
20 UNDERTAKER	**ADDRESS**
A. E. Marshall	358 Gilmor St

tion should be carefully supplied. AGE should be stated EXACTLY. Information as to OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Thomas G. P. Belt.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26042

CERTIFICATE OF DEATH.

45 E 26042

REGISTERED NO.

1-PLACE OF DEATH South Ave. 2nd N. Int Wash 27-54

CITY OF BALTIMORE: (No. Baltimore City St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belt, Thomas Gordon Platt

(a) RESIDENCE NO. South Ave. & 2nd St. - Int. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. 4 ds. 8 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose, Virginia Brown

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 80 | Months | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired, Real Estate Agent

(b) General nature of industry, business, or establishment in which employed (or employer) & Broker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Cty, Md.

PARENTS

10 NAME OF FATHER Belt, Trueman Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince Georges Co. Md.

12 MAIDEN NAME OF MOTHER Ross, Elizabeth Ann

13 BIRTHPLACE OF MOTHER (city or town) Blandensburg P. (State or country) Prince Georges Co. Md

14 Informant Dr. Josiah S. Bowen

(Address) Int. Washington Balto. Md.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 19 27

17 I HEREBY CERTIFY, That I attended deceased from July, 1904, to Sept. 30, 1927,

that I last saw h[illegible] alive on Sept. 30, 1927,

and that death occurred, on the date stated above, at 4:15 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction 1 day.

Carcinoma of Intestines -

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Dr. Josiah S. Bowen, M. D.

, 19 (Address) Int. Washington, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Oct 3 19 27

20 UNDERTAKER: A S Marshall — ADDRESS: 3339 Gall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26043 × 90 E 26043

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Md Gen Hosp St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Shaffer

(a) RESIDENCE NO. Woodlawn Md. St. Ward

(Usual place of abode)

Length of residence In city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long In U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not known

6 DATE OF BIRTH (month, day, and year): 1855 July 5th

7 AGE — Years: 72 — Months: 2 — Days: 25 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Milburn

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant: Hospital records

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 19 27, to Sept 30, 19 27, that I last saw her alive on Sept 30, 19 27, and that death occurred, on the date stated above, at 7:55 A m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Disease with Cardiac Decompensation & hypertrophy Mitral Stenosis 5 minutes

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation 5 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas Davis M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — Date of Burial: Oct 2 1927

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument St

tion should be carefully supplied. Age should be stated in YEARS, MONTHS and DAYS. If LESS than 1 day, hours or minutes should be given. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26044

CERTIFICATE OF DEATH.

E 26044

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hillen Road Hamilton 29-43 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary W. Ormrod

(a) RESIDENCE No. Hillen Road Hamilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Samuel B. Ormrod

6 DATE OF BIRTH (month, day, and year) Feby 22nd 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Alexandra (State or country) Virginia

PARENTS

10 NAME OF FATHER David Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Samuel B. Ormrod

(Address) Hillen Road Hamilton

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1927, to Sept 30, 1927, that I last saw h[illegible] alive on Sept 30, 1927, and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows: Paralysis. left side

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw D Coe M. D.

10/30/1927 (Address) Cor. Eutaw & Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster

DATE OF BURIAL Oct 2nd 1927

20 UNDERTAKER George Schilling & Sons

ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

827
859
65

Spec.–7-17-26—A Co.—200 Blks.

Charles T. Burns

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26045

CERTIFICATE OF DEATH

129 E 26045

63

864

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Balto City Hospital St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Burns

(a) RESIDENCE NO. 2215 Madison Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucretia Burns

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE: Years 63 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Joe Burns

11 BIRTHPLACE OF FATHER (City or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Mrs. Lucretia Burns

(Address) 2215 Madison Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Sept 29, 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-16, 1927, to 9-29-, 1927

that I last saw him alive on 9-29-, 1927

and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

Chronic interstitial nephritis and

Chronic tubular nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sign

(Signed) Boycott, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Delair N.J. Date of Burial Oct 3 1927

20 UNDERTAKER: Jesse E. Wright

ADDRESS 1364 N. Carey

This should be carefully supplied. Avoid using terms not properly classified. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26046

CERTIFICATE OF DEATH

129 E 26046 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1209 Bevard St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Valentine

(a) RESIDENCE NO. 1209 Bevard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred N yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Valentine

6 DATE OF BIRTH (month, day, and year): 7/05, 27—1888

7 AGE: Years 39 Months 10 Days 2

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: James Valentine

11 BIRTHPLACE OF FATHER (City or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Alice Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Alice Harrison (Address) 1209 Bevard St.

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

9-29-27

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1927, to Sept 28, 1927, that I last saw him alive on Sept 28, 1927, and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. I. Hornstein, M. D.

4/30, 1927 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. Date of Burial 8/1/27 19

20 UNDERTAKER: Edward Hensley ADDRESS 578 Bdle

Information should be carefully supplied. Acts should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 26047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 E 26047

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St. 14-20 Ward)

2-FULL NAME Beatrice Stewart

(a) RESIDENCE NO. 1511 Madison Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-11-1900

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	27	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H. maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER O. Edward Dudley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Ely Edwards

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Elizabeth Johnson
(Address) 518 Madison Ave

15 Filed ....., 19 ... per _____ Registrar

C. THAMPSON JONES, M.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) ..... yrs. ..... mos. ..... ds.

Signed _____ M. D.
(Coroner)

, 19 (Address) 1639 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. 4 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Ham Date of Burial 12-2-25 19

20 UNDERTAKER Samuel Stanley ADDRESS Belle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 26048

CERTIFICATE OF DEATH

REGISTERED NO. E 26048

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 12-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Belt

(a) RESIDENCE NO. 103 W. 20th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty-six mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE 56 Years Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER Eliza

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant

(Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 29 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7 1927 to 7-29 1927

that I last saw her alive on 7-27 1927

and that death occurred, on the date stated above, at 9 00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Mitral stenosis & Insufficiency

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. Julian Bond M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial 8-1 1927

20 UNDERTAKER Edward F. Hemsley ADDRESS W. Balto

tion should be carefully supplied. Exact statement of OCCUPATION is
OF DEATH in plain terms, so that it may be properly classified.
very important. See instructions on back of certificates.

Spec. 7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26049

E 26049

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 801 N. Madeira St., 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Michael Kolb

(a) RESIDENCE NO. 801 N. Madeira St. 7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S. if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Margaret Kolb

6 DATE OF BIRTH (month, day, and year): March 4th 1858

7 AGE: Years 69 Months 6 Days 24 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John L. Kolb. (Address) 801 N. Madeira St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 27, to Sept 28, 19 27, that I last saw h[im] alive on Sept 28 19 27 and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhagia Cerebralis

(duration) yrs. 1 mos. hrs. da.

CONTRIBUTORY (Secondary) Arterio Sclerosis

High Blood Pressure

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. Wells M. D.

9/30 19 27 (Address) 3323 E. Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Oct 2nd 19 27

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Hoyt St

Tion should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 26050

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26050

CERTIFICATE OF DEATH.

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 909 Tucker St. 16-22 Ward)

2-FULL NAME Ethel Burrell

(a) RESIDENCE NO. 909 Tucker St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3, 1924.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		8	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Morgan Burrell

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Kidd

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mrs Morgan Burrell
(Address) 909 Tucker St

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1927

17
I HEREBY CERTIFY, That I attended deceased from Sept 23, 1927, to Sept 29, 1927, that I last saw her alive on Sept 29, 1927, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C W Williams Frey, M. D.
(Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial Oct 1, 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 1303 Pressman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26051 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26051.

CERTIFICATE OF DEATH.

REGISTERED NO. 114

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 E 30th ST., 9-46 WARD)

2-FULL NAME Edgar L. McDougal

(a) RESIDENCE NO. 629 E 30th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	3	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edgar L McDougal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Gannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edgar L McDougal
(Address) 629 E 30th St

15 Filed Oct 1 . 19 27 SEC. HEALTH JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1927, to Sept 29, 1927, that I last saw him alive on Sept 29, 1927, and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Convulsion + Heart failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pleurisy (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas W. Sandusen, M. D.

. 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dalmount

DATE OF BURIAL Oct 19 27

20 UNDERTAKER

ADDRESS 702 E Monument

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26052

74-001

74 E 26052

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1824 New Pitts bourgh Ave. St. 37 Ward)

2-FULL NAME John Annisgewski

(a) RESIDENCE NO. 1824 New Pittsburgh St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Annisgewski

6 DATE OF BIRTH (month, day, and year) May 23. - Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheel wright

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) German Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) German Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) German Poland

14 Informant Mrs. Bertha Chell. Daughter

(Address) 1824 New Pittsburgh Ave.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

Sept 30 1927 (Signed) G. C. Klotz M. D.

(Address) 43 E. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Date of Burial Oct. 3. 1927.

20 UNDERTAKER M. J. Ludowski ADDRESS 705 S. Ann St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 26053 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26053

CERTIFICATE OF DEATH. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 907 Parrish ST. 16-22 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Priscilla Smith

(a) RESIDENCE NO. 907 Parrish ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Smith

6 DATE OF BIRTH (month, day, and year): Oct 10, 1854

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
72	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Peter Montague

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ophie Melon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mary J. Smith

(Address) 907 Parrish st

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 24 1927 to Sept 29 1927.

that I last saw h[illegible] alive on Sept 27 1927.

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry F Brown, M. D.

(Address) 1916 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Oct 2, 1927

20 UNDERTAKER: Sam'l H Grave & Son — ADDRESS: 400 Madison

CAUSE OF DEATH is plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Cor.—12-9-25—A Co.—200 Bks.

E 26054

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26054

CERTIFICATE OF DEATH.

177

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 16-37 Ward)

2-FULL NAME Elmer E White

(a) RESIDENCE NO. 1016 St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret

6 DATE OF BIRTH (month, day, and year) May 4-1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O H D

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not known

14 Informant Wm R Hill

(Address) 314 Fleet St.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 hr.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 1 hr.

Oct 1/27 (Signed) H C Wades M. D.

(Coroner)

(Address) 143 W Lexington

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. Date of Burial Oct 3 1927

20 UNDERTAKER George W. Zirkler ADDRESS 1737 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26055 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26055

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3508 O'Donnell St. 26-37 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Riedman

(a) RESIDENCE NO. 3508 O'Donnell ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 50 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Riedman

6 DATE OF BIRTH (month, day, and year) Dec. 11-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	66	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Riedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Minnie Riedman
(Address) 3508 O'Donnell St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from September 9, 1927, to September 30, 1927, that I last saw her alive on September 21, 1927 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs ..... mos 2-3 ds.

CONTRIBUTORY (Secondary) Sclerosis of the Central Nervous System (duration) ..... yrs ..... mos. 21 ds.

18 Where was disease contracted if not at place of death? At the place of work

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) W. A. Ratcliffe, M. D.

10/1, 1927 (Address) 3503 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL Oct. 3 1927

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E. Eager St

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

26056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44

E 26056

REGISTERED No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 619 Parkwyrth Ave. St. 9-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Thomas Owings

(a) RESIDENCE NO. 619 Parkwyrth Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha E. Owings

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	60	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer R.H. Bozman & Bro.

9 BIRTHPLACE (city or town) Friendship,

(State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER William G. Owings

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Miranda Ward

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs. Martha E. Owings

(Address) 619 Parkwyrth Ave.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1st, 19 27, to Sept 29, 19 27

that I last saw him alive on Sept. 28, 19 27

and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Stomach)

(duration) 7 1 yrs. 6 mos ✓ ds.

CONTRIBUTORY (Secondary) Gen'l Debility Family Knowledge

(duration) 7 1 yrs. 6 mos ✓ ds.

18 Where was disease contracted ✓

If not at place of death? ✓

Did an operation precede death? yes Date of Aug 20-1927

Was there an autopsy? no

What test confirmed diagnosis? Personal

(Signed) J. Stanley Simmons M. D.

. 19 (Address) 1401 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery Date of Burial Oct 3 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26057

38 E 26057

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Betty Carroll

(a) RESIDENCE No. 610 S. Wolfe ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1927

7 AGE Years Months Days 20 1/2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Sebastian Carrol

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Juana Lina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant (Address) C.P. Peckham M.D. Johns Hopkins Hospital

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1927

17

I HEREBY CERTIFY, That I attended deceased from 9-8, 1927, to 9-29, 1927, that I last saw her alive on 9-29, 1927 and that death occurred, on the date stated above, at 2 45 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Congenital Syphilis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray Exam.

(Signed) C.P. Peckham, M. D.

10-1-1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL Oct. 1 1927

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS 1710 Fleet St.

CAUSE OF DEATH to be plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HAMPSON JONES, M. D.

Spec.—7-17-26—A Co.—200 Bks.

E 26058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 23 E 26058

1-PLACE OF DEATH U.M.H. REGISTERED NO.

City of BALTIMORE: (No. 33rd & Calvert St. St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Edmond Ralph Kauffman

(a) RESIDENCE NO. Westminster Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 23/27

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min..
		5 weeks		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Westminster Md.

(State or country)

PARENTS

10 NAME OF FATHER Ralph Kauffman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Westminster Md

12 MAIDEN NAME OF MOTHER Mary Essick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Westminster

14 Informant Record.

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10/1/27

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1927, to Oct 1, 1927

that I last saw him alive on Oct 1, 1927

and that death occurred, on the date stated above, at 8 00 A. m.

The CAUSE OF DEATH* was as follows:

Probable Encephalitis.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted home.

If not at place of death?

Did an operation precede death? yes Date of 9/28/27

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R G Belford, M. D.

10-1-1927 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Riders — Date of Burial 10/3 1927

20 UNDERTAKER H B Cashard & Son — ADDRESS Westminster Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 1 1927 THAMPSON JONES, M.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26059
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

199 E 26059
REGISTERED NO.

City of BALTIMORE: (No. Mercy Hosp. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Herron (or Herrin)

(a) RESIDENCE NO. 1125- Druid Hill St. Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ice Cream maker
(b) General nature of industry, business, or establishment in which employed (or employer) Irvin n. Charles
(c) Name of employer 086

PARENTS

9 BIRTHPLACE (city or town) Mobile
(State or country) Alabama

10 NAME OF FATHER Charles Herrin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mobile Ala.

12 MAIDEN NAME OF MOTHER Susie Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Lillie Herrin
(Address) 1125 Druid Hill Ave

15 Filed....., 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. skull -
Stab. by person unknown or from hands
5 days
abm ~~24 hours~~ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

601 (Signed) W. J. Fahey M. D.
(Coroner)
, 19 27 (Address) 1629 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mont Auburn Cem Date of Burial Oct 29 1927

20. UNDERTAKER John J. Owens ADDRESS 538 Dallas

OF DEATH in plain terms, so that it may be properly classified. Each question of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26060

CERTIFICATE OF DEATH.

E 26060

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3341-13th St. 26-37 Ward

2-FULL NAME Josephine Shaffer

(a) RESIDENCE (No.) 3341-13 St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 Color or Race W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Fred S Shaffer.

6 DATE OF BIRTH (month, day, and year) Oct 1906

7 AGE — Years 20 Months 11 Days — IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West Virginia

(State or country)

PARENTS

10 NAME OF FATHER — Bohon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) West Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Fred Shaffer

(Address) 334 13th St.

15 Filed ....., 19.. Sept 27 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mel.

(Duration) Yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) Yrs. mos. 1 ds.

Sept 30/27 (Signed) G C Blades M. D.

(Address) 143 W Berry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morgantown W. Va. Date of Burial 10/11 1927

20 UNDERTAKER J. A. Moran ADDRESS 3909 E. Baltimore

OF DEATH in plain terms, so that it may be properly classified. Entire Statistical of OCCUPATIONS is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26061

CERTIFICATE OF DEATH.

1 84-203

E 26061

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) New Hospital St. H-30 Ward)

2-FULL NAME Mrs. H. Tobias Dorsey

(a) RESIDENCE NO. Cockeville Md St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. / mos. 6d. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of mrs Mary Dorsey

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer self

9 BIRTHPLACE (city or town)

(State or country) Howard Co md.

PARENTS

10 NAME OF FATHER Alfred Dorsey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Howard Co md

12 MAIDEN NAME OF MOTHER Sarah. —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14 Informant Richard Randall

(Address) 708 N. Carey St

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 30 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows

Cuts ACC

Fractur of Skull

Duration ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

Duration ..... yrs. ..... mos. 1 ds.

Oct 1/27 (Signed) (Coroner) M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt George Cemetery Howard Co md. Date of Burial Oct 2 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 130 Pierpont St

OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26062

CERTIFICATE OF DEATH.

E 26062

1-PLACE OF DEATH Mrs. Edmondson Ave R. R. Bridge

City of BALTIMORE: (No. _____ St. B Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dennis Reed

(a) RESIDENCE NO. 1340 N. Calhoun St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) about 1894

7 AGE	Years	Months	Days	If LESS than 1 day ____ hrs. or ____ min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (R. R. Laborer Penn. R.R.)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna R. R.

9 BIRTHPLACE (city or town) _____

(State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Dennis Reed

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md

12 MAIDEN NAME OF MOTHER Fresman Thomas

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md.

14 Informant Darcy Reed

(Address) 537 Roberts.

15 Filed _____, 19 _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Railroad accident
Probably Instantaneous death
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) struck by train
(duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Oct. 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hope Cemetery Calvert Co Md

Date of Burial Oct 2 1927

20 UNDERTAKER Thomas E. Nelson

ADDRESS 1203 Pressman St

OF DEATH in plain terms, so that it may be properly classified. Every answer must be full and complete. Every question must be answered. Information is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26063

CERTIFICATE OF DEATH

E 26063

REGISTERED NO. 13-59

1-PLACE OF DEATH

City of BALTIMORE: (No. 2434 Woodbrook Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Emerich

(a) RESIDENCE NO. 2434 Woodbrook Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adline Emerich

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	76	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Philip Emerich

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Rachel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Adline Emerich

(Address) 2434 Woodbrook Ave.

15 Filed ....., 1927 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1925 to Sept 30, 1927

that I last saw h alive on Sept 30, 1927

and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Lloyd, M. D.

. 19 (Address) 2232 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Hebrew Cem.	10/2/ 1927
20 UNDERTAKER	ADDRESS
Harry Sondheim	115 W. Mt. Royal Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

26064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2046 Bank ST. 1-3 WARD)

REGISTERED NO. 74201 E 26064

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryanna Budacz

(a) RESIDENCE No. 2046 Bank St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Known 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER B. Urbanski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant M. Piechocki Daughter (Address) 2046 Bank st

15 Filed 1927, 19 AKK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 19 27, to Sept 30, 19 27, that I last saw her alive on Sept 30 19 27, and that death occurred, on the date stated above, at 7 PM.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William T. Ryan M. D.

Oct 1, 19 27 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cath	Oct 2 19

20 UNDERTAKER F W Ozozewski ADDRESS 1930 Eastern Ave.

Spec.—1-12-23—M&T—500 Bks.

E 26065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 26065

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1800 Eastern ave (St.) 2-4 (Ward)

2-FULL NAME Kazmierz Niedzwiecki

(a) RESIDENCE NO. 1723 Aliceanna ST. 16 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Helen Niedzwiecka

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Park Board

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER J. Niedzwiecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Z. W. Kazwacki

(Address) 1800 Eastern Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24 , 1927 , to Sept 29 , 1927 , that I last saw h— alive on Sept 29 , 1927 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Aortic & Mitral Regurgitation
Chronic Interstitial Nephritis
Arteio - Sclerosis

(duration) Years yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exam. & Lab.

(Signed) A. Fiss , M. D.

Oct , 1927 (Address) 24 S Penna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 3 — 27 19
20 UNDERTAKER	ADDRESS
F. W. Ozazewski	1930 Eastern Ave

1927 — 2871

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 26066

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26066

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No 4812 Augusta Ave. ST. 27-44 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard R. Ball

(a) RESIDENCE No. 4812 Augusta ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE of~~ Grace M. Bell.

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer G. Alfred Peters Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James I. Ball.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Jane Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dorothy B. Fathers

(Address) 4812 Augusta ave

15 Filed . 19 Registrar

12-1927 RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1927, to Sept. 30, 1927, that I last saw ~~he~~ alive on Sept. 30, 1927, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 10 ds

CONTRIBUTORY (Secondary) Senile Condition

(duration) 1 yr mos. ds.

18 Where was disease contracted if not at place of death? don't know.

Did an operation precede death? no Date of —

Was there an autopsy? no—

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. C. Rannebaker M. D.

. 19 (Address) 2740 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk Cemetery	Oct 3 1927
20 UNDERTAKER	ADDRESS
Wm J Tucker & Sons	Balto Md

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26067 E 26067

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 S. Kenwood ave ST. 1-3 WARD)

2-FULL NAME Elizabeth Bloch

(a) RESIDENCE NO. 314 S. Kenwood ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 9 1863

7 AGE: Years 64; Months; Days; If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Charles Ruckheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Kate Kern

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs L C Williams

(Address) 514 S Kenwood ave

15 Filed ____, 19__ APR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Oct 1, 1927, that I last saw her alive on Oct 1, 1927, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows: Carcinoma Sclerema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chr Int Nephritis

(Duration) yrs. mos. ds.

Chronic myocarditis

18 Where was disease contracted if not at place of death? Presume

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. D. Fuller M. D.

1927 (Address) 3326 Baltic

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Oct 3 1927

20 UNDERTAKER: Johnson Canoles — ADDRESS: 1804 Aisquith st

1927 C. HAMPSON JONES M.D.

TION IS very important. See instructions on

Spec.—1-12-23—M&T—500 Blks.

E 26068

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26068

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 S Bradford St. ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignatuis Edward Zamerski

(a) RESIDENCE NO. 503 S Bradford St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Zamerski

6 DATE OF BIRTH (month, day, and year) July 6 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michael Zamerski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Rutkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Zamerski (Address) 503 S Bradford St.

15 Filed ..., 19 Registrar

TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1927, to Sept. 29, 1927, that I last saw h— alive on Sept. 29, 1927 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (duration), yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. E. & S.

(Signed) John J. Krieger, M. D.

, 19 (Address) 362 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 3 1927

20 UNDERTAKER John M Weber ADDRESS 180 3rd

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26069

CERTIFICATE OF DEATH.

E 26069

REGISTERED NO. 25185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2006 Boyd. St. W-28 Ward)

2-FULL NAME Charles E Peddecord

(a) RESIDENCE NO. 2006 Boyd St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. ½ mos. 21 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 10 - 1927

7 AGE: Years ____ Months ____ Days ½ 21

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Dan Beauchecker

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Jannette E. Sellers

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Jeanette Peddecord (Address) 2006 Boyd.

15 Filed ..... 19 ..... Registrar

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Fall.

Fracture of Skull

(Duration) ½ yrs. ..... mos. 1 hr.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. 1 hr.

Signed ..... M. D.

(City or Town)

Oct 2 '27 (Address) 1430 Riggs

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Pa Date of Burial Oct. 5 1927

20 UNDERTAKER George L. Schwab ADDRESS 410 Lud. St.

2 - 1927 [illegible] THOMPSON-JONES M. D.

Spec.—12-9-25—A Co.—200 Bks.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26070

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 E 26070

REGISTERED NO.

City of BALTIMORE: (No. Sinai Hospital St. 1617 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Volkmans

(a) RESIDENCE NO. 210 Lyons Mills Parkway Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nettie Williams

6 DATE OF BIRTH (month, day, and year): Jan 20 1886

7 AGE — Years: 40 Months: 8 Days: 10 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate operator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Russia

PARENTS

10 NAME OF FATHER M. Williams

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose —

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Russia

14 Informant: Nettie Williams

(Address) 207 Lyons Falls Parkway

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927, to Sept 30, 1927, that I last saw h.. alive on Sept 30, 1927, and that death occurred, on the date stated above, at 10 40 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypostatic pneumonia myocardial degeneration, adrift.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Physical Ex.

What test confirmed diagnosis?

(Signed) Dr. Carl Shelley, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Herschel Memorial Park Date of Burial 10/, 1927

20 UNDERTAKER: Jack Lewis ADDRESS 1137 E. Baltimore St

OF DEATH is plain and complete, and very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 26071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26071

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No. 70-28 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mollie Kallinsky

(a) RESIDENCE NO. 431 S. Pulaski St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Jewish

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Kallinsky Deceased

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years: 70 years; Months: —; Days: —; IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Kiev, — Russia

PARENTS

10 NAME OF FATHER (?)

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Russia.

14 Informant: Mrs. Ida Kuitz

(Address) 426 S. Payson St.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 1, 1927.

17

I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1927, to October 1, 1927, that I last saw her alive on October 1, 1927, and that death occurred, on the date stated above, at 11 55 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage — Arteriosclerosis & Hypertension

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests

(Signed) O J Knapp, M. D.

10-1, 1927 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington [illegible] Date of Burial 10-3 1927

20 UNDERTAKER: Jack Lewis ADDRESS 1434 E. Baltimore St

OF DEATH in pencil only, and make a very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 26072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26072

REGISTERED NO. 1542

1-PLACE OF DEATH

City of BALTIMORE: (No. 2421 Mc Culloh St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thomas

(a) RESIDENCE NO. 2421 McCulloh St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 30-27

7 AGE: Years / Months / Days / IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Richard Thos. Jr.

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Annie Cassell

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Annie Thomas 2421 McCulloh St.

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 1. 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1927, to Oct 1, 1927, that I last saw h[illegible] alive on Oct 30, 1927, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows: Asphyxia Neonal at birth due to suffocation by cord around neck

CONTRIBUTORY (Secondary) Syphilis Congenital (duration) yrs. mos. ds.

18 Where was disease contracted (duration) yrs. mos. ds.

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Pincus, M. D.

. 19 (Address) 2405 E Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

Date of Burial

20

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M & T—500 Bks.

Spec.—1-12-23—MAT—500 Bks.

E 26073

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26073

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2528 Fred'k ave ST. [illegible] WARD)

2-FULL NAME Charley Krieg

(a) RESIDENCE NO. 2144 Hollins ST. 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Minnie J. Krieg

6 DATE OF BIRTH (month, day, and year): July 15. 1887

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
40	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Proprietor

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Fred'k Jun. Krieg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: [illegible] John

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Minnie J. Krieg 2144 Hollins St

15 Filed . . 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25th 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 25, 1927, to Sept 26, 1927, that I last saw him alive on Sept 26, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Peritonitis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary T. B.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ellis Hellman M. D.

9/28, 19 27 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery | DATE OF BURIAL: 9/30 19 27

20 UNDERTAKER: F. C. Wiskert | ADDRESS: 1654 W. Baltimore St

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

26074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26074

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Tuscany Apartments ST. 42-49 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie V. Brady. 40 St. Paul

(a) RESIDENCE NO. Tuscany Apartments ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word) Widow

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Edwin V. Brady

6 DATE OF BIRTH (month, day, and year) Oct 15-1852

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
74	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas L. Lambdin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jane Louise Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Howard W. Brady
(Address) Tuscany Apartments

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927 to Oct 1, 1927.

that I last saw h alive on Oct 1, 1927,

and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Generce metastases

(duration) yrs 3 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of Jan. 1927

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lentz, M. D.

10/27 (Address) Temple Garden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cemetery DATE OF BURIAL Oct 3rd 1927

20 UNDERTAKER Bartlett & Love ADDRESS 1723 Eutaw Pl.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26075

CERTIFICATE OF DEATH

185

E 26075

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2742 St Paul St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Hirsenbaugh

(a) RESIDENCE NO. 2742 St Paul St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18. 1839

7 AGE — Years: 87 Months: 11 Days: 13

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md. Co

PARENTS

10 NAME OF FATHER: Marion Hirsenbaugh

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md Co

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md Co

14 Informant (Address): John L Beck 2702 St Paul St

15 Filed ..... 19 .....

Registrar

RPN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1st. 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 23rd, 1927, to Oct 1st, 1927, that I last saw h[illegible] alive on Oct 1st, 1927, and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

" Uro Endocarditis

Unknown

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Fracture of Hip Joint

..... (duration) — yrs. — mos. 8 ds.

18 Where was disease contracted: C

if not at place of death?: C

Did an operation precede death?: No Date of: C

Was there an autopsy?: No

What test confirmed diagnosis?:

(Signed) Jefferson Buck, M. D.

10/1, 1927 (Address) 110 S. Club Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — Date of Burial: Oct 3 1927

20 UNDERTAKER: H. H. Cook — ADDRESS: 502 E North Ave

OCT 2 - 1927

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26076

CERTIFICATE OF DEATH.

E 26076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1343 Sargent ST.) 21-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Fruburger,

(a) RESIDENCE No. 1343 Sargent ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Fruburger

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John H. Fruburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Hattie Fruburger

(Address) 1343 Sargent St

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1927, to Present, 19, that I last saw him alive on Oct. 1, 1927, and that death occurred, on the date stated above, at 6.50 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Years (duration)

CONTRIBUTORY (Secondary) Chronic Arthritis 2 yrs. mos 21 ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Wm. A. Stearns, M. D.

, 19 (Address) 1201 Griffis Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL Western Cem. DATE OF BURIAL 6/4 1927

20 UNDERTAKER Williamback & Walter ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1927 C. HAMILTON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26077

CERTIFICATE OF DEATH

E 26077

REGISTERED NO. 161-20

1-PLACE OF DEATH

City of BALTIMORE: (No. 3024 E Pratt St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Stillborn~~ Boby Duncklett

(a) RESIDENCE NO. 3024 E Pratt St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept 30 1927

7 AGE: Years — Months — Days —

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER William C Jungblutt

11 BIRTHPLACE OF FATHER (City or town) Baltimore.

(State or country)

12 MAIDEN NAME OF MOTHER Madeline Sommerfield

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Wm C Jungblutt

(Address) 3024 E Pratt St

15 Filed 2 1927 19

Registrar RFD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1927, to Sept 30 1927, that I last saw h— alive on Sept 30 1927, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. C. Jungblutt M. D.

(Address) 3024 E Pratt St

*State the Disease Causing Death, or In deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cem

Date of Burial Oct 1 1927

20 UNDERTAKER John Ulrich

ADDRESS 2008 Aisquith

tion should be directly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26078

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26078

CERTIFICATE OF DEATH

129

27-48

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 705 E.Biddle ST. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice McNally

(a) RESIDENCE NO. 5730 Govane Ave (Govans) St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S. if of foreign birth 33 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of late Felix McNally

6 DATE OF BIRTH (month, day, and year) About 1859

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
About 68 Yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER James McGovern

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Sallie Lee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mr Felix McNally

(Address) 5730 Govane Ave

15 Filed ..... 19 .....

2-1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 30,1927

17 I HEREBY CERTIFY, That I attended deceased from June 2d, 19 26 to Sept 28th, 19 27, that I last saw h[illegible] alive on Sept 28th, 19 27 and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows: Uraemic Coma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Joseph Alexander M. D.

9/30 19 27 (Address) 714 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New Cathedral Cemetery	Oct 3, 1927
20 UNDERTAKER	ADDRESS
Jos Fourchens + Son	217 S. Paca

C. HAMPSON JONES, M. D.

(Secondary) Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Joseph Alexander M. D.

9/30 19 27 (Address) 714 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New Cathedral Cemetery	Oct 3, 1927
20 UNDERTAKER	ADDRESS
Jos Fourchens + Son	217 S. Paca

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

26079 E

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 26079

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 345 S. Stricker St., 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas W. Ellis

(a) RESIDENCE NO. 345 S. Stricker St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina E. Ellis

6 DATE OF BIRTH (month, day, and year) December 26, 1870

7 AGE

Years	Months	Days	IF LESS than 1 day ....hrs. or .... min..
56	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B.&O.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John T. Ellis

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie M. Courtney

13 BIRTHPLACE OF MOTHER (city or town) Washington

(State or country) D. C.

14 Informant Mrs. Nellie Gass

(Address) 1315 N. Fulton Ave.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 29, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 27 to Sept. 29 19 27

that I last saw him alive on Sept. 29 19 27

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. W. Triplett M. D.

10/1, 19 27 (Address) 1324 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	10/3/27 19

20 UNDERTAKER Robert Cook

ADDRESS 1002 W. Baltimore St

IMPORTANT: Should be carefully supplied. Avoid abbreviations. USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 26080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26080

REGISTERED NO. 10-59

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. Central Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Henderson

(a) RESIDENCE NO. 2123 Frances St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M.	B	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane L. Henderson

6 DATE OF BIRTH (month, day, and year) January 1897

7 AGE Years 30 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) VA

PARENTS

10 NAME OF FATHER Robert Henderson

11 BIRTHPLACE OF FATHER (City or town) Richmond VA (State or country)

12 MAIDEN NAME OF MOTHER Bell Curtis

13 BIRTHPLACE OF MOTHER (city or town) VA (State or country)

14 Informant Jane Henderson (Address) 2123 Frances

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-30-1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 28th, 19 27 to Sept 30th, 19 27 that I last saw h[im] alive on Sept 30th, 19 27 and that death occurred, on the date stated above, at 9:20 A. m.

The CAUSE OF DEATH* was as follows:

Ruptured urethra with extravasation of urine ups abdominal wall.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Due to old stricture

Did an operation precede death? Yes Date of 9-29-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture

(Signed) Julius Bidlespell M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. Date of Burial Oct 3 19 27

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS Oxford

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 26081

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1527 E. Pratt St. St., 3-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amy Willis

(a) RESIDENCE NO. 1527 E. Pratt St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Willis

6 DATE OF BIRTH (month, day, and year): June 4 / 1880

7 AGE: Years 47 Months 2 Days 25 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Cambridge (State or country) Md.

PARENTS

10 NAME OF FATHER Jobie Banks

11 BIRTHPLACE OF FATHER (City or town) Cambridge (State or country) Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Cambridge (State or country) Md

14 Informant Emily Hawkins (Address) 614 N. Bradford St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September 29 / 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1927 to Sept 29 1927 that I last saw h.. alive on September 28 1927 and that death occurred, on the date stated above, at 7.20 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Breast with metastases.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Richard Eshleman, M. D.

, 19 (Address) 1514 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery Oct 3rd 1927 Date of Burial

20 UNDERTAKER Milton Davis ADDRESS 316 N Colvin

Filing should be carefully supervised. All items should be filled in. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26082

CERTIFICATE OF DEATH.

11-002

E 26082

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 N. Howard ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Alfred Moore

(a) RESIDENCE NO. 934 N. Howard ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 2, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Market

(c) Name of employer J. Baltimore

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Forbord

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah Moore (Address) 934 N. Howard St.

15 Filed . . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/25 1927 to 10/11 1927 that I last saw h[illegible] alive on 9/29 1927 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Art. of Aorta Syphilis.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Chin, M. D.

(Address) 924 Mass. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Oct 16, 1927

20 UNDERTAKER Mrs. B. A. Elliott — ADDRESS 1727 Eastlund Ave

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26083

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 914 Boyd St. 18-29 Ward)

2-FULL NAME John Dixon

(a) RESIDENCE NO. 914 Boyd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rena Dixon

6 DATE OF BIRTH (month, day, and year): April 8th 1885

7 AGE: Years 42 Months 6 Days 23 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Roy Porter

(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Dixon

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Hester Giles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Rena Dixon 914 Boyd St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/1/ 19 27

17 I HEREBY CERTIFY, That I attended deceased from 9/12/ 27, to 10/1/ 27, that I last saw him alive on 10/1/ 27, and that death occurred, on the date stated above, at 6.40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis. Arteriosclerosis

(duration) about 6 yrs. mos. over ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical-microscopic

(Signed) Dan Bowley, M. D.

(Address) 908 Hart St

10/1/ 19 27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — Date of Burial: 10/4 19 27

20 UNDERTAKER: Walter B. Sprigg's — ADDRESS: 124 W. Hamburg St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26084

CERTIFICATE OF DEATH.

57 E 26084

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 15-68 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamine Humphreys

(a) RESIDENCE NO. 1813 Dukeland St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Isabel Wilmot

6 DATE OF BIRTH (month, day, and year) March 24, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	56	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleman

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. County

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Benj. Humphreys

(Address) 1813 Dukeland St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 1, 1927, that I last saw h~~im~~ alive on Oct 1, 1927 and that death occurred, on the date stated above, at 10 1/2 p m.

The CAUSE OF DEATH* was as follows:

Erysipelas Facialias

(duration) yrs. mos 4 ds

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Myron S. Tull, M. D.

10/2, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL Oct 3rd 1927

20 UNDERTAKER Farrah Bryer — ADDRESS 1600 W North Ave

IMPORTANT—Please print plainly, so that it may be properly classified. TION is very important. See instructions on back of certificates. CTION OF OCCUPA-

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26085

128

E 26085

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 S. Fremont ST. 21-31 WARD)

2-FULL NAME Eliza Springs

(a) RESIDENCE NO. 915 S. Fremont ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a ~~M married~~, widowed, ~~or divorced~~
HUSBAND of (or) WIFE of Steven Springs

6 DATE OF BIRTH (month, day, and year) (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
abt	40	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer (?)

9 BIRTHPLACE (city or town) (State or country) Charlotte N. C.

PARENTS

10 NAME OF FATHER Wm Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Janie Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Rosa Springs (Address) 915 S. Fremont St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1927, to Sept 30, 1927, that I last saw her alive on Sept 30, 1927 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) General Anasarca

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. H. Carroll, M. D.

Oct 1, 1927 (Address) 805 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Cem Oct 3 1927

20 UNDERTAKER — ADDRESS

Daniel Ember Co 916

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26086

CERTIFICATE OF DEATH

40 E 26086

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals S. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rauzie (Reggie) Laws

(a) RESIDENCE NO. 1635 W. Lafayette ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 42 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Truck driver

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Laws

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Bundy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant: Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 30, 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 28, 19 27, to Sept. 30, 19 27, that I last saw h... alive on Sept. 30, 19 27, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. Path's Signed

(Signed) Henry C. Smith, M. D.

9-30-1927 (Address) Path. Dept. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery Date of Burial 10/1/1927

20 UNDERTAKER: Wm. Leo. E. Collard ADDRESS 1631 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26087
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

70 E 26087

CITY OF BALTIMORE: (No. Sydenham Hospital 26-31 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise McArthur Guth.

(a) RESIDENCE NO. 6551 Patapsco St ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life 2 mos 2 ds 18 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	2	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Chas. H. Guth.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Myrtle McCallan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant: Chas. H. Guth
(Address) 6551 Patapsco St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 30, 1927, to Oct 1, 1927, that I last saw h[illegible] alive on Oct 1, 1927 and that death occurred, on the date stated above, at 7 55 a m

The CAUSE OF DEATH* was as follows:

* Encephalitis

(duration) yrs. mos 9 ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Lumbar puncture Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Myron G. Tull, M. D.

10/2 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cemetery	Oct. 3rd 1927
20 UNDERTAKER Lilly & Zeiler	ADDRESS 1403 E. Monument St

TION is very important See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26088

CERTIFICATE OF DEATH.

90 E 26088

1-PLACE OF DEATH Chas & 31st. REGISTERED No. C

CITY OF BALTIMORE (No. Homewood Apts ST.: 12-14 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Josephine Godfrey

(Residence in Baltimore: No. Homewood Apartments St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word): Single

6-DATE OF BIRTH: Apr. 2, 1855 (Month) (Day) (Year)

7-AGE: 72 yrs. 5 mos. 29 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Joseph Godfrey

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Maria Marcy

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen C. Grady

(Address) Homewood Apts.

15-

Filed ..... 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 1, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death (Autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis
Homewood 7 years

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Monroe M. D.

10/2, 1927 (Address) 1632 St. Paul Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS):

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Berlin, Md DATE OF BURIAL: Oct 5, 1927

20-UNDERTAKER: John O. Mitchell & Son ADDRESS: Berlin Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26089

E 26089

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 595 Oxford St. 17-24 Ward)

2-FULL NAME Isiah Queen

(a) RESIDENCE NO. 595 Oxford St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colrd

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Teresa Queen

6 DATE OF BIRTH (month, day, and year): Sept. 16, 1898

7 AGE: Years 29 Months Days 14 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Bal to. City Md.

(State or country)

PARENTS

10 NAME OF FATHER Isiah Queen

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Queen

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Md.

14 Informant: Dorcetta Jones

(Address) 1320 Penna Ave

15 Filed_____ 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Kenney M. D.

(Coroner)

Sept. 30, 1927 (Address) 2572 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. Date of Burial Oct 3rd 1927

20 UNDERTAKER: Harmon Eldridge ADDRESS 1364 Mass Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26090

CERTIFICATE OF DEATH.

66

E 26090
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 595 Offord St. St. 17th Ward)

2-FULL NAME Teresa Queen

(a) RESIDENCE NO. 595 Offord St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isiah Queen

6 DATE OF BIRTH (month, day, and year): Oct. 3, 1902

7 AGE: Years 24 25 Months 11 Days 27

IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 31

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER: Dorsey Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Dorotha Meyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Dorotha Jones

(Address) 2220 E Lanvale

15 Filed ..... 19 ..... R.H.H. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Oct. 2, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cushing Date of Burial Oct 3rd 1927

20 UNDERTAKER: Garrett L. Wright ADDRESS 514 N. Carey

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26091

CERTIFICATE OF DEATH.

74-001 E 26091

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 S. Patterson Park Ave ST., 1 WARD) 3

2-FULL NAME Susie Meurer

(a) RESIDENCE NO. 505 S. Patterson Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gustav A. Meurer

6 DATE OF BIRTH (month, day, and year): May 16, 1866

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or min.
61	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Frederick Koehler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Gerken

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Gustav A. Meurer

(Address): 505 S. Patterson Park Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15 1923 to Oct. 1st 1927.

that I last saw her alive on Oct. 1st 1927

and that death occurred, on the date stated above, at 5-30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs

(Signed) Edna Shaler, M. D.

10/5/27, 19 (Address) 4005 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cems — DATE OF BURIAL: Oct 4 1927

20 UNDERTAKER: H. Sanders Sons — ADDRESS: 1710 Pleasant

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26092

CERTIFICATE OF DEATH

90 E 26092

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 126 E. Barney St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Sullivan

(a) RESIDENCE NO. 126 E. Barney St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Sullivan

6 DATE OF BIRTH (month, day, and year): July 27, 1844

7 AGE: Years 83 Months 7 Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER: Hiram Henry

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Mrs. Mary Kane

(Address): 130 E. Fairmount Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1927, to Sept 30, 1927.

that I last saw h.. alive on Sept 30, 1927

and that death occurred on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Senile myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Hans Sayer M. D.

(Address) 6 E. Randall St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. | Date of Burial: Oct 3. 1927

20 UNDERTAKER: J. Marquette & J. Flynn | ADDRESS: 1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26093

CERTIFICATE OF DEATH.

188-003

E 26093

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Union Memorial Hosp 3-54 St., Ward)

2-FULL NAME Charles N. Hiku

(a) RESIDENCE NO. 1514 Lakeside Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): Mar. 8 1865

7 AGE — Years: 62 Months: 6 Days: 22 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md

PARENTS

10 NAME OF FATHER: John B. Hiku

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Rauch

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: Mrs J. P. Reisinger

(Address): 1514 Lakeside Ave.

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

18* CAUSE OF DEATH* was as follows:

Injuries from Auto accident

Accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Norman (Coroner) M. D.

Oct. 1927 Address 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Oct. 3 1927

20 UNDERTAKER: Wm. J. Tucker & Son ADDRESS: North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26094

CERTIFICATE OF DEATH.

170 E 26094

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Southern Hotel 19-50 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Murr

(a) RESIDENCE NO. 25-03 W. Paul St Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr. Frank L. Noyes

6 DATE OF BIRTH (month, day, and year): June 3. 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
50	50	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Fred. Murr

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Anna Burkhoff

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Mrs. Frances Murr

(Address) 25-03 W. Paul St.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and from (Inquest, autopsy or inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol shot wound in brain

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) .....yrs. .....mos. .....ds.

Oct 2 (Signed) A. J. Ruhrah M. D.

(Coroner)

. 1927 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 1 yrs. 2 mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

18 PLACE OF BURIAL, CREMATION OR REMOVAL: Three Rivers, Mich. Date of Burial: Oct 5 1927

20 UNDERTAKER: J. J. Linker Sons ADDRESS: Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 26095

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓

REGISTERED NO. E 26095

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick L. Stafford

(a) RESIDENCE NO. 1731 Lamont Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) March 29/23

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	5 6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Patrick Stafford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Patrick Stafford
(Address) 1731 Lamont Ave

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rabies - Bitten by dog Aug 10/27
(Autopsy at St. Joseph Hospital. Brain examined by Balto. City Health Depart
(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Patton (Coroner) M. D.

10/3/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial 10/4 1927

20 UNDERTAKER George J Ruth 1735 ADDRESS Harford

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26096

E 26096

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 Stanwood Ave ST., 26-41 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian V. Byrnes

(a) RESIDENCE No. 32 Stanwood Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3 | 11 | 27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George F. Byrnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y. City

12 MAIDEN NAME OF MOTHER Helen Rockfeller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

14 Informant George F. Byrnes
(Address) 32 Stanwood Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 1, 1927

that I last saw her alive on Oct 1, 1927

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) yrs 7 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Harding, M. D.

, 19 (Address) Belair Rd - Valley View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL 10/4 1927

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

IMPORTANT—See instructions on back of certificates.

OCT 3 - 1927 C. HAMPTON

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26097 — REGISTERED NO. E 26097

1-PLACE OF DEATH

City of BALTIMORE: (No. 2805 N. Forth Ave St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie T. Cassell

(a) RESIDENCE NO. 2805 N. Forth Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Wm. H. Cassell

6 DATE OF BIRTH (month, day, and year): Nov. 21, 1857

7 AGE — Years: 69 — Months: 10 — Days: 12

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country) Md

PARENTS

10 NAME OF FATHER: Joseph Harris

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Wm. H. Cassell

(Address) 2805 N. Forth Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 3 1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1927, to Oct 3, 1927,

that I last saw her alive on Oct 3, 1927,

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia, Cause

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jno. Dreany Thomas, M. D.

Oct 3, 1927 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

Date of Burial: Oct 5 1927

20 UNDERTAKER: Robt. L. Little

ADDRESS 2700 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 3 - 1927

R 1171

Spec.—1-12-25—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26098

CERTIFICATE OF DEATH

90 E 26098

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 547 S Paca (Ward) 92-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME BENJAMIN LIVENGOOD

(a) RESIDENCE No. 547 S Paca ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Livengood

6 DATE OF BIRTH (month, day, and year) No. 1873

7 AGE 54 Years — Months — Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) No.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salisbury Penna.

PARENTS

10 NAME OF FATHER D. Livengood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER C. Burkhelder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) No.

14 Informant Elizabeth Livengood (Address) 547 S Paca St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1927, to Oct. 2, 1927, that I last saw him alive on Oct. 1, 1927 and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (Decompensation)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Anthony V. Bubiedes, M. D.

, 19 (Address) 37 S. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Meyersdale Pa. DATE OF BURIAL: Oct 5. 1927

20 UNDERTAKER: John Grebliauckas ADDRESS: 423 S Paca St

1927 HAMPDEN M. D.

TION IS very important. See instructions on back of certificate.

Spec 47-17 2 A Co.—200 Bks.

L 26099

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

122-002

L 26099

REGISTERED No.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSP[illegible] 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lewis.

(a) RESIDENCE NO. 912 Plum alley Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Isaac Lewis

6 DATE OF BIRTH (month, day, and year) ?

7 AGE — Years: 55 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Polly ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant BALTIMORE CITY HOSP[illegible]

(Address) [illegible]

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29/1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 24. 1927 to Sept. 27. 1927 that I last saw h[illegible] alive on Sept. 29. 1927 and that death occurred, on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver - Secondary

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Sub

(Signed) C. Holmes Bond, M. D.

. 19 (Address) BALTIMORE CITY HOS[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

Mt. Zion Cem — 9/30 1927

20 UNDERTAKER — ADDRESS

C. A. Brown's Son

C 3 - 1921 W. SARATOGA ST. - BALTIMORE

BALTIMORE CITY HOSPITALS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26100

CERTIFICATE OF DEATH.

90 E 26100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 W Pratt. ST. 18-29 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Asa W. Weiler.

(a) RESIDENCE NO. 1008 W Pratt. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of. Bridget D Weiler.

6 DATE OF BIRTH (month, day and year) Dec 5, 1878

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48.	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. 1

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Christian Weiler

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizab Payne.

13 BIRTHPLACE OF MOTHER (City or town) (State or country) New York.

14 Informant Mrs. Bridget D. Weiler (Address) 1008 W Pratt.

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1927

17

I HEREBY CERTIFY, That I attended deceased from 4/29/1927, to 10/1/27, 19, that I last saw him alive on 9/30/27, 19, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) General Anasarca

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard J. Fay, M. D.

10/1, 1927 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Oct 4 1927

20 UNDERTAKER: John J Cowan & Son ADDRESS: 901 Hollins St.

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26101

CERTIFICATE OF DEATH.

100 E 26101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 250 Maryland Ave ST. 25th WARD 3

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME B. Eugene Hann

(Residence in Baltimore: No. 250 Maryland Ave, Westport St.: 1 yrs., 9 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec (Month) 13 (Day), 1925 (Year)

7-AGE, 1 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City.

PARENTS.

10-NAME OF FATHER, Claude Hann

11-BIRTHPLACE OF FATHER (State or Country), Balto County

12-MAIDEN NAME OF MOTHER Sarah Frey

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Claude Hann

(Address) 250 Md. Ave. Westport.

15-

Filed ....., 191.... Registrar.

OCT 3 - 1927 THAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 1 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1927, to Oct 1 1927, that I saw her alive on Oct 1 1927, and that death occurred, on the date stated above, at 7.50 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Lawrence Wheeler M. D.

Oct 1st 1927 (Address) Halsted & Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Oct. 3..., 1927
20-UNDERTAKER Nelson E Stiles	ADDRESS 231 Md Ave Westport

Important: See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 26102

CERTIFICATE OF DEATH.

90 E 26102

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1704 W. Fayette (St.) 1992 (Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Hensel

(a) RESIDENCE (Usual place of abode) No. 1704 W. Fayette St. 19 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. \ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~WIFE of~~ (or) WIFE of John Hensel

6 DATE OF BIRTH (month, day, and year) Oct 9 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md USA

PARENTS

10 NAME OF FATHER Burkhart L. Menecken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Harriet Mecklenburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) John Hensel 1704 W. Fayette St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1927, to Sept 29, 1927, that I last saw her alive on Sept. 29, 1927, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. \ mos. \ ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustavus L. Dohme M. D.

9/29 1927 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 3 1927
20 UNDERTAKER	ADDRESS
George Smith	1532 Hollins

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26103 — REGISTERED NO. E 26103

1-PLACE OF DEATH

City of BALTIMORE: (No. 4817 Delaware ave St. 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis A. Essert

(a) RESIDENCE NO. 4817 Delaware ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Eva J. Essert

6 DATE OF BIRTH (month, day, and year) Apr 27 1871

7 AGE: Years 56 Months 5 Days 4 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner, Jr.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER George Essert

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Lout Rhow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Joseph Essert

(Address) 5604 Allenbrake Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1927, to Oct 1, 1927, that I last saw him alive on Oct 1, 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

1 Uraemia

(duration) yrs. mos. 7 ds

CONTRIBUTORY (Secondary) prostatitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles F. Luce M. D.

. 19 (Address) 24 E Fort Wyoming Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — Date of Burial Oct 4 1927

20 UNDERTAKER Robt J Turner — ADDRESS N Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26104

CERTIFICATE OF DEATH.

114 ✓

REGISTERED No. E 26104

1-PLACE OF DEATH

City of BALTIMORE: (No. 943 Montpelier St St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha M. Ward

(a) RESIDENCE NO. 943 Montpelier St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	S

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27/24

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or....min.
	3	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James S. Ward

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Bertha Olfers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Bertha Ward

(Address) 643 Montpelier St

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 30 Oct 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) ....and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Indigestion

(duration) ....yrs. ....mos. ....ds.

CONTRIBITORY (Secondary) Convulsions

(duration) ....yrs. ....mos. ....ds.

(Signed) J. M. Prince M. D.

(Coroner)

19 (Address) 10/3/27 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Oct 3 1927

Date of Burial

20 UNDERTAKER Otto O. Kruger ADDRESS 422 N. Bway.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Blks.

E 26105 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 26105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 Lynhurst ave ST. 10-70 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J Chambers

(a) RESIDENCE NO. 416 Lynhurst ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Virginia Chambers

6 DATE OF BIRTH (month, day, and year) April 5 69

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John T Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ogden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs A V Chambers
(Address) 416 Lynhurst ave

15 Filed ..... 19 ..... RLP Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 2 .19.27. to Oct 2 .19.27.

that I last saw him alive on Oct 2 .19.27.

and that death occurred, on the date stated above, at 9:50 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic - adhesions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) ..... Geo. L. Wilson ..... M. D.

. 19 (Address) 4006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL All Saints Cemetery Catonsville Md

DATE OF BURIAL Oct 4 1927

20 UNDERTAKER W M Routson

ADDRESS 2228 N ~~Arlington~~

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26106

CERTIFICATE OF DEATH.

44 E 26106

1-PLACE OF DEATH William Tierney

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 418 WARD)

2-FULL NAME ~~[illegible]~~

(a) RESIDENCE NO. 1310 Wist St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred life ds. How long in U. S., if of foreign birth? life ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~[illegible]~~

6 DATE OF BIRTH (month, day, and year) 3-1-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	7	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Jobbing
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William T Tierney

11 BIRTHPLACE OF FATHER (city or town) Ireland.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Grody.

13 BIRTHPLACE OF MOTHER (city or town) Ireland.
(State or country)

14 Informant Mrs Margaret Samuel.
(Address) 1310 Wist St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-1-22, 19

17 I HEREBY CERTIFY, That I attended deceased from 8-29-22, 19 , to 10-1-22, 19 ,
that I last saw h alive on 10-1-22, 19 ,
and that death occurred, on the date stated above, at 11:30 P. m.
The CAUSE OF DEATH* was as follows: .
Cancer of Liver.
(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) ~~[illegible]~~
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Hemmy E. Doyle M. D.
, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 10-4-1922.

20 UNDERTAKER Martin Fahey & Son — ADDRESS 1217 North Ave

PRO. is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26107

CERTIFICATE OF DEATH.

185 E 26107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 S. Randall St. 24-24 WARD)

2-FULL NAME Ella Bowen O'Neill

(a) RESIDENCE NO. 408 S. Randall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno. C. O'Neill

6 DATE OF BIRTH (month, day, and year) Sept. 22. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) Own Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Alb. M. Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto'.

12 MAIDEN NAME OF MOTHER Juliet Howell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto'.

14 Informant Vera O'Neill

(Address) 408 S. Randall St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1st 1927

17

I HEREBY CERTIFY, That I attended deceased from 9.5.27, 19 , to 10.1.27, 19 ,

that I last saw her alive on 10-1-27, 19 ,

and that death occurred, on the date stated above, at 8.20 A m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Fracture 5th. Cervical Vertebra

(duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical-X-Ray-Clinical & microscopic.

(Signed) Philip B. Taylor, M. D.

10.1.27, 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 10/31/1927

20 UNDERTAKER E. C. Fanning Cont. — ADDRESS 1460 Battery Av.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Jean L Helwig

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26108

REGISTERED NO. E 26108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 Eutaw Pl. St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean Louise Helwig

(a) RESIDENCE No. 1537 N. Bentalou St., WARD

(Usual place of abode) (If non-resident: give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 24 1927

7 AGE	Years	Months	Days	If LESS than 1 day 16 hrs or — min.
	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo A. Helwig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lunenburg Va

12 MAIDEN NAME OF MOTHER: Mary Louise Hamm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Geo A. Helwig 1537 N. Bentalou St.

15 Filed , 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27th 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 24th, 1927, to Oct 27th, 1927, that I last saw her alive on Oct 27th, 1927 and that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Hunner M.D.

Oct 27, 1927 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Oct 31 1927

20 UNDERTAKER: Harry W. Ellen

ADDRESS: W North Ave

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26109 — REGISTERED NO. 89 E 26109

1-PLACE OF DEATH

City of BALTIMORE: (No. 1604 N. Eutaw St. St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward B. Barros

(a) RESIDENCE NO. 1604 N. Eutaw St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion Barros.

6 DATE OF BIRTH (month, day, and year) Oct. 20, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
54	55	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sergeant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. A.

9 BIRTHPLACE (city or town) Chicago

(State or country)

PARENTS

10 NAME OF FATHER Henry L. Barros

11 BIRTHPLACE OF FATHER (city or town) Ga

(State or country)

12 MAIDEN NAME OF MOTHER Claude Elmo

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ga

14 Informant Marion Barros

(Address) 1604 Eutaw St.

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Oct. 1, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
National Cemetery	10/3 1927
20 UNDERTAKER	**ADDRESS**
Sol Kirman & Bro.	E Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Robert Shuttleworth

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 26110 — CERTIFICATE OF DEATH — + 92 E 26110

REGISTERED No. C

1 PLACE OF DEATH 100 E 23rd — (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. St Paul St 7234 — St.: 12-50 — WARD)

2 FULL NAME Robert Shuttleworth

(Residence in Baltimore: No. Clarksburg W Va — St.: yrs. mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male / ~~Female~~

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (If wife the word): Married

6 DATE OF BIRTH: May (Month) 3 (Day), 1862 (Year)

7 AGE: 65 yrs. 5 mos. ds. — If LESS than 1 day, ... hrs. or .... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Officer Consolidation Coal Co
(b) General nature of industry, business, or establishment in which employed (or employer): Ofc

9 BIRTHPLACE (State or country): Clarksburg W Va.

PARENTS

10 NAME OF FATHER: Benj F Shuttleworth

11 BIRTHPLACE OF FATHER (State or country): West Va

12 MAIDEN NAME OF MOTHER: Miriam Blair

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia G Shuttleworth
(Address) 743 Maple Av Clarksburg W Va

15 Filed ..... 191 ... R H K REGISTRAR

OCT 3 - 1927 HEALTH DEPT. M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 3 (Day), 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1927, to Oct 3 1927,
that I saw h[illegible] alive on Oct 2, 1927,
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:

Arterio sclerosis
Coronary Thrombosis

(Duration) yrs. mos. 1 ds

Contributory (SECONDARY) Arterio sclerosis

(Duration) 3 yrs. mos. ds.

(Signed) Harry S Beall M. D.
Oct 3, 1927 (Address) St Paul & 23d St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Masonic Cemetery Clarksburg W Va — DATE OF BURIAL: Oct 5 1927

20 UNDERTAKER: Harry H Maxwell — ADDRESS: 430 Adgewood Av

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

200786

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26111

E 26111

+90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 79 WARD)

2-FULL NAME Eugene Wilson

(a) RESIDENCE NO. Dickeyson Pl ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. ..... mos. 2wks ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Daisy Wilson

6 DATE OF BIRTH (month, day, and year) 1-20-71

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	56	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pastrycook

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware

(c) Name of employer Construction Co Tech D.C.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Eisenhauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Eugene Wilson
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Oct. 2, 1927, that I last saw him alive on Oct. 2, 1927 and that death occurred, on the date stated above, at 5-15 A m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency
(complicated by mesenteric thrombosis)

(duration) 2(?) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) mesenteric thrombosis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Oct. 1, 1927

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) I. Ridgeway Trimble, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland

DATE OF BURIAL Oct 5 1927

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26112

CERTIFICATE OF DEATH.

E 26112

1-PLACE OF DEATH

REGISTERED NO. 161-001

City of BALTIMORE: (No. 2222 Oak. Av St., 12-51 Ward)

2-FULL NAME ~~John Doe~~ John McGill

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 2222 Oak Av St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M. | 4 Color or Race: W. | 5 Single, Married, Widowed, or Divorced, (write the word): —

3a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/1/28

7 AGE: Years — | Months 2m | Days — | IF LESS than 1 day ..... hrs. or 6 min.

Gramkis -

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country)

PARENTS

10 NAME OF FATHER ~~John Doe~~ Paul McGill

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country)

12 MAIDEN NAME OF MOTHER ~~Mary Roe~~ Catherine McGill

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country)

14 Informant ..... (Address)

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/1 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

10/1, 1927 (Address) 2222 Oak Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL Date of Burial 19

20 UNDERTAKER ..... ADDRESS .....

1927 C. HAMPSON JOHNS HOPKINS HOSPITAL

Burial Permit

Cor.—12-9-26—A Co.—200 Bks. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. E 26112

1-PLACE OF DEATH

City of BALTIMORE: (No. 2222 Oak Av St., 12 Ward)

2-FULL NAME John McGill

(a) RESIDENCE NO. 2222 Oak Av St. 12 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M. | 4 Color or Race: W. | 5 Single, Married, Widowed, or Divorced, (write the word): —

3a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/1/28

7 AGE: Years — | Months 2m | Days — | IF LESS than 1 day ..... hrs. or 6 min.

Premature

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country)

PARENTS

10 NAME OF FATHER Paul McGill

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country)

12 MAIDEN NAME OF MOTHER Catherine McGill

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country)

14 Informant Hospital (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

1927 APR 11 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/1 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

Spec.-7-17-26—A Co.—200 Bks.

E 26113

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26113

CERTIFICATE OF DEATH

38

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 26-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Grant

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Sam Grant

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Jane ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant BALTIMORE CITY HOS...

(Address) Re...

15 Filed ..., 19 ... Registrar

OCT 1927

1756 - ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/1/ 1927

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1927 to Oct. 1, 1927

that I last saw deceased alive on Oct. 1, 1927

and that death occurred, on the data stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

Myocardial degeneration

Arteriosclerosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gen. Exam.

(Signed) C. Hudson Jones, M. D.

, 19 (Address) BALTIMORE CITY HOS...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

UNIVERSITY OF MARYLAND

20 UNDERTAKER — ADDRESS, 1927 OCT 3

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26114

CERTIFICATE OF DEATH

E 26114

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 304 N. Carroll (St., Ave., etc.) (WARD)

2-FULL NAME Margarethe Nugent

(a) RESIDENCE No. 304 N. Carrollton ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Timothy Nugent

6 DATE OF BIRTH (month, day, and year) Sept 5 1832

7 AGE Years 95 Months Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Barbdulf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant James McCurley

(Address) 304 N Carrollton ave

15 Filed ..., 19... Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927, to Sept 1, 1927, that I last saw h[illegible] alive on Sept 1, 1927, and that death occurred, on the date stated above, at 11 O'Clock m.

The CAUSE OF DEATH* was as follows:

Acut Inflamed gallbladder

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acut dilation heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct 2 1927 (Address) 904 N Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Oct 4 1927

20 UNDERTAKER J. A. Moran ADDRESS 320 E. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26115

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26115

CERTIFICATE OF DEATH.

T 129

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 7-9 (WARD)

2-FULL NAME James Tyler

(a) RESIDENCE NO. Morristown Tennessee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Tyler

6 DATE OF BIRTH (month, day, and year) 9-22-86

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41 years		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work automobile mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Hale Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mamie Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant

(Address) Unknown

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-2 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Oct 2, 1927, that I last saw him alive on Oct 2, 1927, and that death occurred, on the date stated above, at 9-20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial failure following chronic nephritis with hernia

(Uncertain)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. L. Faulkner, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Morristown Tennessee. DATE OF BURIAL Oct 3 1927

20 UNDERTAKER Charles F Evans ADDRESS 1180 Eutaw Place

Spec.–7-17-26—A Co.—200 Bks.

E 26116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 26116

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6605- 5th Ave St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Carl

(a) RESIDENCE NO. 6605- 5th Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Carl

6 DATE OF BIRTH (month, day, and year) May 28- 1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	73	4	4.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John Carl

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hemmelmann

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Germany

14 Informant Mrs. Mary L. Carl

(Address) 6605 5th Ave

15 Filed ..... 19 ..... Registrar

C. HARRISON JONES, M.D.

1927

NKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 2- 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1927 to Oct 2 1927

that I last saw h— alive on Oct 1 1927

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease - Arteriosclerosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Learmonth M. D.

19 (Address) Dundalk. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Balto. Cem	10-4 1927
20 UNDERTAKER	ADDRESS
John Ulrich	2008 Orleans

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E26117 HEALTH DEPARTMENT—CITY OF BALTIMORE VE 02 6117

CERTIFICATE OF DEATH.

REGISTERED NO. 12

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1820 Presstman ST. | 5-21 WARD

2-FULL NAME Pauline Oliver

(a) RESIDENCE No. 1820 Presstman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 40 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Spot Oliver

6 DATE OF BIRTH (month, day, and year) DEC 10 - 64

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rebecca Stones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Maggie Oliver Neal (Address) 1820 Presstman

15 Filed OCT 3 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 1 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1927, to Sept. 30, 1927, that I last saw h alive on 9 - 30 - 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart & Hypertrophic Cirrhosis of Liver

History about 6 yrs. Personal knowledge about 1 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis? none

(Signed) George Chase M. D.

10-3, 1927 (Address) 1562 Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cem DATE OF BURIAL Oct 3 1927

20 UNDERTAKER Sam'l R. Chase Son ADDRESS 1400 Madison

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26118 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26118

CERTIFICATE OF DEATH. X 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Rosenblatt Wiener

(a) RESIDENCE NO. Waynesboro, Pa. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Wiener

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mansbach, (State or country) Germany

PARENTS

10 NAME OF FATHER Solomon Rosenblatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Buxbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Simon Wiener

(Address) Waynesboro, Pa.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 . 1927 . to Oct. 3 . 1927 . that I last saw h[illegible] alive on Oct. 3 . 1927 and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Stethoscope

(Signed) Hiram Fried . M. D.

3/10 . 1927 (Address) 1010 St. Paul Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Hebrew Friendship Cem. DATE OF BURIAL 10/ 5/ 1927

20 UNDERTAKER David Sondheim ADDRESS 118-20 W. Mt. Royal Ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26119

CERTIFICATE OF DEATH.

1882 E 26119

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mtr Hospital St. Ward)

2-FULL NAME Clarence Lee

(a) RESIDENCE NO. 1407 Madison Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 29-1916

7 AGE: Years 9 Months Days If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: L. F. Lee

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Susie Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Sophie Bradford

(Address): 1407 Madison

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Auto Acc

Injury to Spleen & Stomach

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. ..... ds.

Oct 2/27 (Signed) G C Hales M. D.

(Coroner)

(Address) 143 Rosemary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Oct 4 27

20 UNDERTAKER: Daniel Easton ADDRESS: Cath

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

86-002

86 E 26120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 N. Bond ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice R. Hatfield

(a) RESIDENCE NO. 1321 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wilbur Hatfield

6 DATE OF BIRTH (month, day, and year) April-16-1894.

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs. or min.
	33	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 0 "T

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William H. Cuddy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Priscilla Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Wilbur Hatfield (Address) 1321 N. Bond St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1 1927

17

I HEREBY CERTIFY, That I attended deceased from September 26 1927. to October 1 1927.

that I last saw h e alive on October 1 1927.

and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation.

Toxemia - Nephritis.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? Yes Date of August 17 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William H. Schwarz M. D.

10/1. 1927 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Oct 4 19 27
20 UNDERTAKER	ADDRESS 3617
Ehrenwerth & Son	Chestnut Ave

Spec.—1-12-23—M&T—500 Bks.

E 26121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 ✓

E 26121

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hosp.

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 12-51 WARD)

2-FULL NAME Miss Stella Feldpush. c

(a) RESIDENCE NO. 2644 Huntington Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) W S & G.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Ferdinand Feldpush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Dockhorf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Celia Feldpush (Address) 2644 Huntington Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1927, to Oct 3, 1927, that I last saw her alive on Oct 3, 1927, and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows:

Acute Salpingitis. oophoritis.

Partial intestinal obstruction

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes. Date of 9/17/27.

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) T. P. Thompson, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 10/7 1927

20 UNDERTAKER Edward Fowler — ADDRESS 225 E Fayette St

HOW is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26122

E 26122

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4101 Resistertown Rd ST. 15-54 WARD)

2-FULL NAME John D. Schaefer

(a) RESIDENCE NO. 4101 Resistertown Rd ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

4 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Schaefer

6 DATE OF BIRTH (month, day, and year): July 6 1860

7 AGE: Years 67 Months 2 Days 25 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Automobile Repair Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Anna Schaefer 4101 Resistertown Rd

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 1. 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 26. 1927. to Oct. 1. 1927.

that I last saw him alive on Oct. 1. 1927.

and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Left Hemiplegia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): General Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James D. Askenhurst, M. D.

10-21-27 (Address) 4012 Park Hgts ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery

DATE OF BURIAL: Oct 4 1927

20 UNDERTAKER: H S Marshall

ADDRESS: 3539 Fall Rd

TION IS VERY important. See instructions on

Spec.—1-12-23—M&T—500 Blks.

Dr Truland 1319 Poplar Grove St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26123

CERTIFICATE OF DEATH.

31 E 26123

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 2867 N. Lanvale St. 16-61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Donforth

(a) RESIDENCE No. 2867 N Lanvale St, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cameron Donforth

6 DATE OF BIRTH (month, day, and year) June 2. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Ralph Md

PARENTS

10 NAME OF FATHER Henry Hilton

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hisey

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md

14 Informant Cameron Donforth

(Address) 2867 N Lanvale St

15 Filed ..... 19 RMK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1927 to Oct 1 1927, that I last saw her alive on Oct 1 1927, and that death occurred, on the date stated above, at 4:50 m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) ✓ yrs. ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) John J. Truland M. D.

10/2 1927 (Address) 1319 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Oct 4 1927

20 UNDERTAKER H. H. Cook — ADDRESS 501 E South St

TION IS very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 26124

E 26124
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. Sinai Hosp. St. 1521 Ward)

2-FULL NAME Mr. Morris Stulman

(a) RESIDENCE NO. 1705 N. Payson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie Stulman

6 DATE OF BIRTH (month, day, and year): —1877

7 AGE: Years 50; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Miner - Plumber

(b) General nature of industry, business, or establishment in which employed (or employer): 59

(c) Name of employer

9 BIRTHPLACE (City or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Simon Naftula Stulman

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Brima

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: J. Lewis

(Address): 1439 E. Balto. St.

15 Filed 10-4- 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927 to Oct. 4, 1927, that I last saw h. alive on Oct. 4, 1927, and that death occurred, on the date stated above, at 4.45 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Gangrene of right leg

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. Hyman, M. D.

10/4, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rossdale Date of Burial 10-4- 1927

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balto. St.

A/H/C

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26125 ✓ 29 E 26125

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 140 N. Luzerne St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Ann Bramble

(a) RESIDENCE NO. 140 N. Luzerne St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3/1858

7 AGE — Years: 69 | Months: 8 | Days: 28 | If LESS than 1 day..... hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Dorchester Co
(State or country): Md

PARENTS

10 NAME OF FATHER: John Ed. Bramble

11 BIRTHPLACE OF FATHER (city or town): Dorchester
(State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah J. Brown

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Dorchester

14 Informant: Virginia Jones
(Address): 140 N. Luzerne

15 Filed....., 19..... , Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 3, 1927, that I last saw h[illegible] alive on Oct 3, 1927, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. P. Hearn M.D. M. D.

19 (Address) 1305 N Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial

Druids Church Dorchester Co. Oct 1927

20 UNDERTAKER: J. A. J. Kerr ADDRESS: 15 N. Luzerne

very important. See instructions on back of certificate. EXACT statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26126

CERTIFICATE OF DEATH.

100-09 E 26126

1-PLACE OF DEATH

City of BALTIMORE: (No. 5209 Belmont St. 27-55 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maurice H Jackson

(a) RESIDENCE NO. 5209 Belmont St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M.	C.	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/2/26

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER J. Jackson.

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Ga

12 MAIDEN NAME OF MOTHER Mary Marshall

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Kentucky

14 Informant Mary Marshall

(Address) 5209 Belmont Ave.

15 Filed _____ 19__ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (autopsy or inquiry.) thereon and from the evidence obtained by said inquest (autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) John H. Kummer M. D.

(Coroner)

10/3. 19 27 (Address) 1632 Eland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — Date of Burial Oct. 4, 19 27

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

OF DEATH in plain terms, so that it may be very important. See instructions on back of certificate.

Loneesome

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26127

CERTIFICATE OF DEATH.

90 E 26127

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1525 N Saratoga St. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Loneesome

(Residence in Baltimore: No. 1525 N. Saratoga St.; 33 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 22 (Day), 1894 (Year)

7-AGE, 33 yrs. 2 mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Ansley

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Estella Howard

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Loneesome

(Address) 1525 Saratoga st

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 1 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-29-27 191.., to 10-1-27 191.., that I saw h[illegible] alive on " 191.., and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

acute Uremia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) acute nephritis

(Duration) yrs. 1 mos. ds.

(Signed) [illegible] M. D.

10-3-, 1927. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Oct. 4th, 1927

20-UNDERTAKER A. Jones ADDRESS W. d. Gelmer

[illegible] HANSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26128

CERTIFICATE OF DEATH.

31 E 26128

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1625 Faith Lane Ward 8-13)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Johnson

(a) RESIDENCE NO. 1625 Faith Lane. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grant Knox

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: About 35 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Keysville

(State or country) Va

PARENTS

10 NAME OF FATHER: Louis Bailey

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va

12 MAIDEN NAME OF MOTHER: Amanda Jones

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va.

14 Informant: Lettie Ricks

(Address) 1625 Faith Lane

15 Filed....., 19..... C. HARRISON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable intraabdominal Hemorrhage

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Possibly Tuberculosis

(duration) .....yrs. .....mos. .....ds.

(Signed) J. M. Catlin M. D.

(Coroner)

10/4/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem. Mrs. R.A. Elliott. Date of Burial: Oct 4 1927

20 UNDERTAKER: 1725 Orkdand ave ADDRESS

Be sure that all items are answered, or that it may be plainly shown that the information cannot be obtained. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26129

REGISTERED NO. 129 E 26129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1170 Warner St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Gross

(a) RESIDENCE NO. 1170 Warner St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): unk

7 AGE: Years 49 Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): unk 070

(c) Name of employer: unk.

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Jesse White

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Margaret Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Madeline Turner

(Address) 1170 Warner St.

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/31 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/28 1927, to 10/31 1927, that I last saw h[illegible] alive on 10/2 1927, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no. Clinical

What test confirmed diagnosis?

(Signed) [illegible], M. D.

10/31 1927 (Address) 908 S Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. Date of Burial: Oct 4 1927

20 UNDERTAKER: A Leon Hall ADDRESS 453 Dolphin

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CITY REGISTRAR [illegible], M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Ced 26130

CERTIFICATE OF DEATH.

101-001

E 26130

REGISTERED NO.

1-PLACE OF DEATH [illegible] HOSPITAL

CITY OF BALTIMORE: (No. 1-13 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert James

(a) RESIDENCE No. 822 N. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col-	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz. James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents (Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 4 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1927, to Oct 1, 1927, that I last saw him alive on Oct. 1, 1927, and that death occurred, on the date stated above, at 11:15 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 822 N Dallas

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL Oct. 4 1927

20 UNDERTAKER Chas. H. Johnson + Co. ADDRESS 16 N. Carrollton Ave.

Spec. 6-9-19 H. P. Co.—1000 Blks.

E 26131

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26131

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: No 3528 Frederick Ave St. 9 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter J. Lauer

(a) RESIDENCE NO. 3528 Frederick Ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds How long in U. S. if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma C Lauer

6 DATE OF BIRTH (month, day, and year) April 7 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jacob Lauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Volk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Emma C Lauer
(Address) 3528 Frederick Ave

15 Filed OCT 4 1927, 19 C. HAMPSON JONES, M. D., Registrar
Per P. Ellis

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3 1927

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1927, to October 3, 1927, that I last saw him alive on October 2, 1927, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Angina pectoris (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac paralysis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical symptoms

(Signed) John C Connell, M. D.

10/5, 1927 (Address) 804 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 6 19
20 UNDERTAKER	ADDRESS
John J Fild	1200 W Lombard

THIS is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26132 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26132

CERTIFICATE OF DEATH. 131

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 W. Lombard ST. 3-5 WARD)

2-FULL NAME Annie M. Nixon

(a) RESIDENCE No. 1226 W. Lombard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Nixon

6 DATE OF BIRTH (month, day, and year) Feb. 12, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Landers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. May Nixon

(Address) 1226 W. Lombard

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2nd. 1927

17 I HEREBY CERTIFY, That I attended deceased from August 30th 1926 to Oct. 2nd. 1927.

that I last saw h alive on Oct. 2nd. 1927

and that death occurred, on the date stated above, at 4 Pm

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 10 Yrs.

Pyelitis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Caleb O'Connor M. D.

, 19 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Oct 5 19 27

20 UNDERTAKER John Shields ADDRESS 1200 W. Lombard

Spec.–7-17-26—A Co.—200 Bks.

Gubl.

E 26133

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26133

100-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Guhl

(a) RESIDENCE NO. 632 Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer) 0000

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Germany

PARENTS

10 NAME OF FATHER Julius Guhl.

11 BIRTHPLACE OF FATHER (City or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany

14 Informant _____

(Address) Relative

15 Filed _____, 19 _____

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2/ 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 19 27, to Oct. 2, 19 27,

that I last saw him alive on Oct. 2, 19 27

and that death occurred, on the date stated above, at 2:10 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - general & cerebral. Hypertension. Paralysis of extrems.

(duration) P yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? General a Symptoms.

(Signed) C. Hulbert Boyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Carmel	Oct 4 1927
20 UNDERTAKER Mundell Hoffberger	ADDRESS 378 N

Par _____

Or DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26134

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26134

CERTIFICATE OF DEATH

REGISTERED NO. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. 2010 W. Eldersy St., 74 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mary Herfel

(a) RESIDENCE NO. 2010 W. Eldersy St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. J. Herfel

6 DATE OF BIRTH (month, day, and year): Jan. 4, 1867

7 AGE: Years 60 Months 8 Days 27 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town): Balto, Md.,

(State or country)

PARENTS

10 NAME OF FATHER: George Schmitt

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Gertrude Delsh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Wm. J. Herfel

(Address) 2010 W. Eldersy St.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 1 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to Oct 1- 1927, that I last saw h[illegible] alive on Oct 1- 1927, and that death occurred, on the date stated above, at 8-2 p- m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ..... yrs. 4½ mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Arrhythmia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Chem. Lab. Tests.

(Signed) G. C. Wades, M. D.

Oct 2 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — Date of Burial: Oct. 5, 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26135 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 1-1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lanigan.

(a) RESIDENCE NO. 202 E. Preston ST., 1 WARD
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ellen Lanigan

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	2	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Mark Lanigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McDermott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records HOSPITAL
(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Oct 2, 1927, that I last saw him alive on Oct 2, 1927, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

of symptoms
(duration) 1 yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Cachexia, anaemia Incident to course of disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Robt. L. Faulkner, M. D.

, 19.... (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL Oct 5 1927

20 UNDERTAKER Lilly + Zeller

ADDRESS 40 S. Wolfe St

Spec.—12-9-25—A Co.—200 Bks.

E 26136

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 26136

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 76-1 Ward)

2-FULL NAME Frank Kropfelder.

(a) RESIDENCE NO. 3314 Hudson St. / Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 8 1927

7 AGE: Years — Months: 8 — Days: 25 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER: Geo. Kropfelder

11 BIRTHPLACE OF FATHER (city or town): Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Ruff.

13 BIRTHPLACE OF MOTHER (city or town): Balto. Md.

(State or country)

14 Informant: Geo Kropfelder

(Address) 3314 Hudson St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-3-27 19

17 I HEREBY CERTIFY, That I attended deceased from 10-2- 19 27 to 10-3 19 27

that I last saw h in alive on 10-3 19 27,

and that death occurred, on the date stated above, at 8:05A m.

The CAUSE OF DEATH* was as follows:

Malnutrition -
Bilateral Bronchial Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Harry Weinteub, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Redeemer Cem Oct. 5 1927

20 UNDERTAKER: Lilly & Zeile

ADDRESS 403 S. Wolfe St

Very important. See instructions on back of certificates. Full statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

E 26137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24

E 26137

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp 3-31 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Doris Reinke

(a) RESIDENCE NO. 1429 S Charles St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3 1927

7 AGE — Years — Months: 6 mos. — Days — IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER Chas. Reinke

11 BIRTHPLACE OF FATHER (City or town) Balt. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mildred Rhea

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md

(State or country)

14 Informant Mother

(Address) 1429 S. Chas. St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct. 3, 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1927, to Oct 3, 1927, that I last saw her alive on Oct 3, 1927, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis (Streptococcus)

(duration) ....yrs. ....mos. 2 1 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Bedford, M. D.

10-3 1927 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

Baden Rhea Cem

20 UNDERTAKER — ADDRESS

J. Hampton Jones, M. D. Oct 4 1927

J. Hampton Jones & Son Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26138

E 26138

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 W. Hamilton St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. King

(Residence in Baltimore: No. 2121 W. Hamilton St.: 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	C. [illegible]	Single

6-DATE OF BIRTH, ... (Month) ..... (Day), 1877 (Year)

7-AGE,	If LESS than 1 day,
50 yrs. ..... mos. 1 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John King

(Address) 2121 W. Hamilton St.

15-

Filed ....., 191.... HAMPSON JONES, M. D. Registrar.

OCT 4 - 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 1, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3 1927, to Oct 1 1927, that I saw h[illegible] alive on Oct 1 1927, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypostatic

(Duration) 3 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ..... yrs. ..... mos. ? ds.

(Signed) [illegible] M. D.

Oct 4, 1927 (Address) 5 S. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death about 2 yrs. ..... mos. ..... ds. In the State 20 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Calvary Cem.	Oct 4, 1927
20-UNDERTAKER	ADDRESS
J. Smith Sadler	1027 Reid Hill Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26139

CERTIFICATE OF DEATH

10 E 26139

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals St. 16-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Smothers

(a) RESIDENCE NO. 1022 W. Lexington st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Smothers

6 DATE OF BIRTH (month, day, and year) March 6th 1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter's helper

(b) General nature of industry, business, or establishment in which employed (or employer) 0/6

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Smothers

11 BIRTHPLACE OF FATHER (City or town) Calvert Co

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alberta Bailey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1927, to Oct. 1, 1927,

that I last saw him alive on Oct. 1, 1927,

and that death occurred, on the date stated above, at 1.35 A. m.

The CAUSE OF DEATH* was as follows:

Multiple Lung Abscess, Effects of Abscess of Wall of Abdomen (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Clinical

(Signed) C. E. Mallory M. D.

10-1-1927 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Int. Auburn Cemetery	10-5-1927

20 UNDERTAKER Thos. Isaac L. Bailey ADDRESS 1721 Jefferson

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Dr Smith 47 Stafford Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26140

CERTIFICATE OF DEATH.

94-002 E 26140

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Abbottson ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jacob Snyder

(a) RESIDENCE NO. 1623 Abbottson ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5yr. yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Georgia Snyder

6 DATE OF BIRTH (month, day, and year) DEC 23 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Underwear Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Regatta Mfg Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John J. Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Ruth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Georgia Snyder

(Address) 1623 Abbottson

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1927, to Oct 3, 1927, that I last saw h alive on Oct 3, 1927 and that death occurred, on the date stated above, at 8:25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lloyd Jones, M. D.

10/4/27 (Address) 6706 Kingsmore Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Graham N. C. DATE OF BURIAL Oct 4 1927

20 UNDERTAKER William Cook ADDRESS 502 E North

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26141

CERTIFICATE OF DEATH

31 E 26141

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto. City Hosp. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Walston

(a) RESIDENCE NO. 6 Whitelock + Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1910

7 AGE: Years 17 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Union Walton~~

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Abram Walston

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N.C.

12 MAIDEN NAME OF MOTHER Maggie Reddick

13 BIRTHPLACE OF MOTHER (city or town) ~~Cold~~

(State or country) N.C.

14 Informant Hospital Records

(Address) Balto City Hosp.

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct 2 27.

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 19 27 to Oct 2, 19 27

that I last saw h alive on Oct 2, 19 27

and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Pul. Tb.

Tuberculous Pneumothorax

Melancholia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Melancholia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) A. L. Madden, M. D.

10/2 19 27 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Mills N. G. Date of Burial: Oct 4 19 27

20 UNDERTAKER: David Easton ADDRESS 516 Pa ave

4 - 1927

IMPORTANT—Answer all questions in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 26142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1602 E 26142

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fountain Square Home ST. 70-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Kunicka

(a) RESIDENCE NO. 3411 W. Fayette ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 4, 1927

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or 22 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ludwig Kunicka

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mabel Birrell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Ludwig Kunicka
(Address) 3411 W. Fayette St.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-4-1927 to 10-7-1927

that I last saw h[illegible] alive on 10-7-1927

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Breech Presentation, with asphyxiation in last moments of delivery - in Primipara

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) O. B. Hofman M. D.

, 19 (Address) 2500 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 10/4/27

20 UNDERTAKER: Harry A. Wilhelm — ADDRESS: 1531 W Lanvale St

TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M.W.S. 1500 Blks.

E 26143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 26143

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 210 Ridgewood Rd. (ST.) 27-5 (WARD)

2-FULL NAME Charles Ogle Seull

(a) RESIDENCE NO. 210 Ridgewood Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ann H. Miller

6 DATE OF BIRTH (month, day, and year) Nov 27. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	75	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vice Pres. U.S.F.&S. Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Banking, Bonding Ins.

(c) Name of employer U.S.F.&S.Co.

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Edward Seull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Louisa Ogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Ann H. M. Seull

(Address) 210 Ridgewood Road

15 Filed ..... 19 ..... Registrar

Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3. 1927

17 I HEREBY CERTIFY, That I attended deceased from July 12. 1927. to Oct-3. 1927.

that I last saw h(im) alive on Oct-3. 1927.

and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma of the Right Kidney

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? X-Ray of Kidney.

(Signed) M. Tilson Porter M. D.

10/3. 1927 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburgh, Penna. DATE OF BURIAL Oct 6 19 27

20 UNDERTAKER John C. Mitchell & Son ADDRESS 1900 Eutaw Pl

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26144

CERTIFICATE OF DEATH

90 E 26144

1-PLACE OF DEATH Univ Hospital REGISTERED NO.

City of BALTIMORE: (No. 154 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Eileen Sweitzer

(a) RESIDENCE NO. 2104 Allendale Rd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): 1918

7 AGE: Years 9 Months 7 Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Edward Sweitzer

11 BIRTHPLACE OF FATHER (City or town): Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER: Ella Huber

13 BIRTHPLACE OF MOTHER (city or town): Baltimore Md

(State or country)

14 Informant: Mrs. Audrey Sweitzer

(Address): 2104 Allendale Rd

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 2, 1927, that I last saw her alive on Oct 2, 1927 and that death occurred, on the date stated above, at 4.45 a.m.

The CAUSE OF DEATH* was as follows:

Rheumatic Carditis. Thrombus present a Mucoid Adherent Pericarditis

(duration) ..... yrs. 7 mos. ..... da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 1st 1927

Was there an autopsy? No (Pericardotomy)

What test confirmed diagnosis? Clinical

(Signed) E. E. Hodges, M. D.

Oct 3 27 Address 1 E. Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: Oct 5, 1927

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E. Eager St.

OR DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26145

CERTIFICATE OF DEATH.

122-001

REGISTERED NO. E 26145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 E. Chase St. 10-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh P. Byrnes

(a) RESIDENCE NO. 919 E. Chase ST. ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Nettie C Byrnes

6 DATE OF BIRTH (month, day, and year) Jun 8, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3 2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant & Cafe

(b) General nature of industry, business, or establishment in which employed (or employer) Owner

(c) Name of employer in Business for Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Miles Byrnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Nettie C. Byrnes (Address) 919 E. Chase St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1927, to Oct 2, 1927, that I last saw h— alive on Oct 1927, and that death occurred, on the date stated above, at 1200 a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis of Liver

Unknown (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Edward Gill M. D.

10/3, 1927 (Address) 614 E. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 6 19

20 UNDERTAKER Edward H. Conklin — ADDRESS 929 E Eager St.

Spec.—1-10-21—M&T—1500 Bks.

E 26146

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26146

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3800 Dorchester Road (ST.) 15-1-27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A. Mass.

(a) RESIDENCE NO. 3800 Dorchester Road (ST.) (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma E Mass

6 DATE OF BIRTH (month, day, and year) Jan 30th 1851

7 AGE Years 76 Months 8 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Mass.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Susanna Shinbolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant (Address) Mrs Emma E Mass 3800 Dorchester Road

15 Filed ... 19 ... M. ... Registrar

C. HAMPTON MOORE, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 30 1927 to Oct 2 1927.

that I last saw h alive on Oct 2 1927.

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry W. Bayley, M. D.

Oct 3 1927 (Address) 2805 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Oct 5 1927

20 UNDERTAKER Kettlewell & Lore — ADDRESS 1723 W. Lafayette Ave

TION is very important. See instructions on back of certificates.

E 26147

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 26147

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1600 North Port Street St. 8-16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2 FULL NAME Stefan Bancsits

(Residence in Baltimore: No. 1600 North Port Street St.; 14 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~, ~~MARRIED~~, WIDOWED OR ~~DIVORCED~~ (write the word): Widower

6 DATE OF BIRTH: August (Month) 13th (Day), 1863 (Year)

7 AGE: 64 yrs. 1 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Bass Moelter

9 BIRTHPLACE (State or country): Hungary

PARENTS

10 NAME OF FATHER: not known

11 BIRTHPLACE OF FATHER (State or country): not known

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (State or country): not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Bancsits

(Address) 1600 N Port St.

15 Filed OCT 4 1927 C. HAMPSON JONES, M. D. REGISTRAR

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 1st (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 11th 1927. to. October 1st 1927. that I saw him alive on October 1st .1927. and that death occurred, on the date stated above, at 12 p. m.

The CAUSE OF DEATH* was as follows:

carcinoma of larynx

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Asthma

(Duration) yrs. 2 mos. ds.

(Signed) Francis Wm Hartley-Hellmer M. D.

Oct 2nd 1927 (Address) 1204 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore Hem

DATE OF BURIAL: Oct 4th 1927

20 UNDERTAKER: Leo. G. Cook

ADDRESS: 1723 Patt Pk Ave

PLACE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26148

38 E 26148

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 569 Ward) BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sara Boden

(a) RESIDENCE NO. 211 W. Saratoga St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Boden

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Millie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address) [illegible]

15 Filed ..... 19 .....

Registrar

1750 RLS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1927, to Sept. 30, 1927, that I last saw her alive on Sept 30, 1927 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis - secondary

(duration) ..... yrs. ? mos. ..... ds.

CONTRIBUTORY .....

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? General & Sale

(Signed) C. Hudson Wright, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

4 very important. See instructions on back of certificate. ...property classified. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

See Letter in file from Dr C Holmes Boyd dated 10-17-1927

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26149

90 E 26149

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St., 5-K Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Kelly

(a) RESIDENCE NO. 632 Fulton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. da.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) April ? 1886 ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ?

(State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) BALTIMORE CITY HOSPITALS

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/1/1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1926, to Oct. 1, 1927

that I last saw her alive on Oct. 1, 1927.

and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic

Arteriosclerosis

(duration) yrs. ? mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross & Sale

(Signed) C. Holmes Boyd, M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leonard buried in Mt Zion Date of Burial Oct 19 1927

20 UNDERTAKER Edward Bryan 1631 ADDRESS

1758 ARH

Be sure that every blank is filled in plain terms, so that it may not be misunderstood. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26150

CERTIFICATE OF DEATH

44 E 26150

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hosp St. K 2K-64 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Stein

(a) RESIDENCE NO. 4205 Springhill Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Stein

6 DATE OF BIRTH (month, day, and year) Jan 29 1868

7 AGE: Years 59 Months 8 Days 1

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saw Mill Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Adam J. Stein

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records

15 Filed 10-4 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 9/30/27, 19..., to 10/3, 19 27,

that I last saw h... alive on 10-3, 19 27,

and that death occurred, on the date stated above, at 7:40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Pancreas, Gall Bladder

(duration) SEVERAL yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? YES Date of 10/1/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos. A. Stein M. D.

10/3 1927 (Address) 1003 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEMETERY — Date of Burial 10/6/27 19

20 UNDERTAKER: Joseph F. Cook — ADDRESS 1003 N Calvert St

4-1927 P.M. C. HAMPSON JONES, M.D. APH

very important. See instructions on back of certificates.

...ck of certificates. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26151

CERTIFICATE OF DEATH

7-4-00 E 26151

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 100 S. East Avenue St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ann Elliott

(a) RESIDENCE NO. 100 S. East Avenue St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gideon Elliott

6 DATE OF BIRTH (month, day, and year) March 12, 1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	73	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Addison

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant G. R. Elliott

(Address) 100 S. East Avenue

15 Filed , 19

Registrar

4-1927 C. HAMPSON JONES, M.D.

RKW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st 19 26 to Oct 2 - 19 27.

that I last saw h er alive on Oct 2 - 19 27.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Herrman M. D.

10/2 19 27 (Address) 1710 E. 33rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Olivet	10/6/27 19
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26152

CERTIFICATE OF DEATH.

38 E 26152

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hospt.

City of BALTIMORE: (No. Balto Md. St. 16 Ward)

2-FULL NAME Richard J. Batter

(a) RESIDENCE NO. 1039 W. Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): September 14, 1878

7 AGE: Years 49 | Months 0 | Days 17 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Grocery Store

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: William Batter

11 BIRTHPLACE OF FATHER (city or town)

(State or country): England

12 MAIDEN NAME OF MOTHER: Ethey Danahey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Balto City Hospital

(Address): Balto Md.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-1-'27

17 I HEREBY CERTIFY, That I attended deceased from 9-17- 1926 to 10-1 1927, that I last saw h[illegible]ive on 9-30- 1927 and that death occurred, on the date stated above, at 2.05 A. m.

The CAUSE OF DEATH was as follows:* Terminal Bronchopneumonia

CONTRIBUTORY (Secondary) Labor Paresis Lactic Infection (duration) ... yrs. 1 mos. ... ds.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) Philip Barlow M. D.

10/1, 1927 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — Date of Burial: 10/5 1927

20 UNDERTAKER: Joseph B Cook — ADDRESS: 1003 W. Baltimore St

very important. See instructions on back of

Spec.–7-17-26—A Co.—200 Bks.

E 26153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90E 26153

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Miller

(a) RESIDENCE NO. 41 W. Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. if of foreign birth 47 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days
	56		

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Rumania

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Rumania

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Rumania

14 Informant

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/3/1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1927, to Oct. 3, 1927, that I last saw her alive on Oct. 3, 1927 and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic acute

Diabetes Enterocolitis

(duration) 22 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? P.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Sect.

(Signed) C. Holmes Bond, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbrew Baedall — Date of Burial 10/5 1927

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Baltimore

OCT 4 1927

C. HAMPSON JONES, M. D.

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26154

CERTIFICATE OF DEATH.

E 26154

1-PLACE OF DEATH Pronounced dead at the

City of BALTIMORE: (No. South Baltimore General Hospital Ward) 24-33

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Minarik.

(a) RESIDENCE NO. 15th St. Brooklyn Park A. A. Co. Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) February 8, 1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Bohemia.

PARENTS

10 NAME OF FATHER Joseph Minarik.

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Bohemia.

12 MAIDEN NAME OF MOTHER Anna Jezek.

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Bohemia.

14 Informant Louis Minarik. (brother)

(Address) 2 Cedar St. Curtis Bay.

15 Filed _____, 19__ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Electrocuted.
By aerial crossing electric wires.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) Otto Bernhardt M. D.
(Coroner)

10/4. 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? 15th St. Brooklyn Park, A. A. Co. 10/3/27

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill C. of C. Date of Burial 10-7-27

20 UNDERTAKER Ernest Cockran ADDRESS 1906 Aliceanna St.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26155

CERTIFICATE OF DEATH.

E 26155

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N Port ST. 6-10 WARD)

2-FULL NAME Catherine Wieman

(a) RESIDENCE NO. 18 N Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Wieman

6 DATE OF BIRTH (month, day, and year) March 27 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad for Wenderspan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John Ruth 18 N Port

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1927 to Oct. 3, 1927

that I last saw her alive on Oct. 3, 1927

and that death occurred, on the date stated above, at 1:50 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pessagno M. D.

10.4.27 (Address) 514 Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Oct 7 1927

20 UNDERTAKER Windell Offel & Son — ADDRESS Balto

Spec.—1-12-23—M&T—500 Bks.

E 26156

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26156

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 Park Ave. ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mair, Katherine Ridinger

(a) RESIDENCE NO. 1739 Park Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac F. Ridinger

6 DATE OF BIRTH (month, day, and year): Jan. 1866

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
61	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Christman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Maria Lemmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Isaac F. Ridinger.

(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10. 2. 1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1926, to Oct 2d, 1927, that I last saw h[illegible] alive on Oct 1st, 1927, and that death occurred, on the date stated above, at 4,00 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma in left side of chest pressing on the heart

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Stewart, M. D.

10,2. 1927 (Address) 211 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Park Cemetery

DATE OF BURIAL: Oct 5 1927

UNDERTAKER: William Cook

ADDRESS: 501 E North

Spec.—1-12-23—M&T—500 Bks.

Norton. 888 W. Lumbard.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26157

CERTIFICATE OF DEATH.

113 E 26157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S Caton St St. 18-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Barrett

(a) RESIDENCE NO. 119 S. Caton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1927

7 AGE: Years 9 Months 5 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edward Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Veronica Rubel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Laura A. Cullen

(Address) 520 Oakley St.

15 Filed , 19

ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3. 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 2. , 1927, to Oct 3. , 1927;

that I last saw her alive on Oct 2. , 1927;

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Acute Otitis - Catarrhal -

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Thos. Norton, M. D.

Oct 4. 1927 (Address) 888 W. Lumbard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lawn Cem. DATE OF BURIAL Oct 7 19 27

20 UNDERTAKER H. Colvin Sons ADDRESS

Spec.—1-12 23—M&T—500 Bks.

See letter in file

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26158

CERTIFICATE OF DEATH.

E 26158

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 438 Aisquith ST., 5-A.m. (WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Feinson

(a) RESIDENCE NO. 438 Aisquith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Harris 1856

6 DATE OF BIRTH (month, day, and year) Sept 15 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71 ~~73~~	—		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hanna Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Henry Feinson 438 Aisquith St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1926, to Oct 4, 1927, that I last saw h[illegible] alive on Oct 4, 1927, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Harnstein M. D.

10/4 1927 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave — DATE OF BURIAL Oct 5 1927

20 UNDERTAKER J Feinson Bro — ADDRESS 1127 E Balto St

Spec.—1-12-23—M&T—500 Blks.

E 26159

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26159

CERTIFICATE OF DEATH.

118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1845 W. Lexington ST. 20-27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice M. Rickey

(a) RESIDENCE NO. 1845 W. Lexington ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles T. Rickey.

6 DATE OF BIRTH (month, day, and year) Aug. 4, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Michaels (State or country) Md.

PARENTS

10 NAME OF FATHER Wrightson Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Edna M. Taylor

(Address) 1845 W. Lexington St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1927, to Oct 2, 1927, that I last saw h[illegible] alive on Oct 2, 1927, and that death occurred, on the date stated above, at 11.05 P m

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

Generalized Arteriosclerosis.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Strangulated Hernia.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm Michel, M. D.

Oct 4 1927. (Address) 290 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL Oct 5 1927

20 UNDERTAKER Wm Nicholsons ADDRESS Nord & Pa

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26160

CERTIFICATE OF DEATH.

59-002

159 E 26160

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 311 S Madeira ST., 1-3 WARD)

2-FULL NAME Geraldine Brody

(a) RESIDENCE No. 311 S. Madeira 21 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6y. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 26-26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Anthony Brody

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Petro Augusta

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs A Brody
(Address) 311 S Madeira St

15 Filed ..... , 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1927. to Oct. 3, 1927.
that I last saw him alive on Oct. 3, 1927
and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) marasmus

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Szyborski, M. D.

, 19 (Address) 1730 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Oct 1927

20 UNDERTAKER J. W. Ozgurski ADDRESS 1930 Eastern

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 26161

CERTIFICATE OF DEATH.

E 26161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Bank St ST., 2-4 WARD)

2-FULL NAME Katarzyna Guzska

(a) RESIDENCE NO. 2021 Bank ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Oct 25 - 26

7 AGE: Years — Months: 11 — Days: 8. — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Guzski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Wanda Rydzewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: James Guzski (Address) 2021 Bank St

15 Filed ..19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1927, to Oct 3, 1927, that I last saw h— alive on Oct 3, 1927, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Rymarcz M. D.

Oct 4 1927 (Address) 804 Kane St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Oct 7 1927

20 UNDERTAKER: J W Ozazewski — ADDRESS: 1930 Eastern

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26162

CERTIFICATE OF DEATH.

113 ✓ E 26162

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2327 Dinsem St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Butler

(a) RESIDENCE NO. 2327 Dinsem St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Infant

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Wilbert Butler

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Katie Lane

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Katie Butler

(Address) 2327 Dinsem St.

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 4, 1927, that I last saw him alive on Oct 1, 1927, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Acute Ileo Colitis

(duration) .....yrs. .....mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

10/4, 1927 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Cem Oct 5 1927

20 UNDERTAKER — ADDRESS

Harold Easton 946 Pa ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26163

CERTIFICATE OF DEATH.

18 E 26163

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Harbor. Penn & Washington St. St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Hajnowski

(a) RESIDENCE NO. 2601 Fait Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married But not living to gether

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Antonina Hajnowski

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years 45; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steveder

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Poland.

(State or country)

PARENTS

10 NAME OF FATHER: Kazmier Hajnowski

11 BIRTHPLACE OF FATHER (city or town): Poland

(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): Poland.

(State or country)

14 Informant: Antonina Hajnowski.

(Address) 2601 Fait ave.

15 Filed....., 19.....

Registrar

RRR

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

4/27/27 (Date) 1423 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetery Date of Burial Oct 5 1927

20 UNDERTAKER: George A. Weber ADDRESS 2205 Bank st

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

207/02 E 26164

CERTIFICATE OF DEATH.

13-52/13 E 26164

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. 13-52 ST., WARD) REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Hearl

(a) RESIDENCE No. 2731 Falls Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced. (~~write the word~~)
Female	White	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22-1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	2 mos	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest Hearl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed 10/14, 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct-1, 1927, to Oct-4, 1927, that I last saw her alive on Oct-4, 1927, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Marasmus + enterocolitis

(duration) 5 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) I. R. Trunk, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden — DATE OF BURIAL Oct 5 1927

20 UNDERTAKER Thomas Watson — ADDRESS 3616 Chestnut Ave.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26165

CERTIFICATE OF DEATH.

E 26165

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 219 W 27th St. ST. 12-51 WARD)

2-FULL NAME George E. Clutz.

(a) RESIDENCE No. 219 W 27th St. ST., .. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE of~~ Daisy M. Clutz.

6 DATE OF BIRTH (month, day, and year) March 14 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice Cream Manufactu

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Daisy M. Clutz. (Address) 219 W 27th St.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4. 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 15 .1927. to Oct 3 .1927. that I last saw h alive on Sept 29 .1927. and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

L.B.P. 220/180

Indefinite

(duration) ..... yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) 1 Month yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) R. B. Norwood M. D.

Oct 4. 1927 (Address) 3615 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Thurmont Md.	Oct 7, 1927
20 UNDERTAKER Chenowith & Son	ADDRESS 3615 Chestnut Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26166

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

24-001

24-34

E 26166 REGISTERED NO.

City of BALTIMORE: (No. South Baltimore General Hospital St. (If Hospital, Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph B. Pumphrey.

(a) RESIDENCE NO. 1827 Belt St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Married.

5a If married, XXXXXXXXXXXX HUSBAND of XXXXXXXXX Mary A. Pumphrey.

6 DATE OF BIRTH (month, day, and year) April 19, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER Thomas Pumphrey.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Cromwell.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) A. A. Co. Md.

14 Informant Mary A. Pumphrey. (wife)

(Address) 1827 Belt St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas. Reinhardt M. D.
(Coroner)

10/4 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. To the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1827 Belt St. Oct. 1, 1927

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem Date of Burial Oct 6 1927

20 UNDERTAKER L. Lankenau Sons ADDRESS Baltimore

very important. See instructions on back of certificate.

OCT 6 1927 C. HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26167

CERTIFICATE OF DEATH.

117

E 26167

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

City of BALTIMORE: (No. ____ St., 7-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Kern

(a) RESIDENCE NO. 510 N. Roberton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widower not given

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Kern

6 DATE OF BIRTH (month, day, and year): July 10. 1865

7 AGE — Years: 62 — Months: 1 — Days: 24 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: Julius Fries

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Thomas Kern

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Austria

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Not known

14 Informant: Henry Kern

(Address): 510 N. Roberton St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 – 4 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-2 1927, to 10 – 4, 1927, that I last saw him alive on 10 – 4, 1927, and that death occurred, on the date stated above, at 12 50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis with Rupture of Appendix

Generalized Peritonitis (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Terminal Bronchio-Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 10-2-27

Was there an autopsy? no

What test confirmed diagnosis? clinical - surgical

(Signed) A. Krupp, M. D.

10-5, 1927 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — Date of Burial: Oct. 7 1927

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: 1110 Fleet St.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26168

CERTIFICATE OF DEATH.

10-E 26168

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 1-1 WARD)

2-FULL NAME Dolores Weiss

(a) RESIDENCE NO. 910 S. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	7	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Weiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Rahley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Edw. Weiss
(Address) 910 S. Linwood Ave

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1927, to Oct 4, 1927.

that I last saw h alive on Oct 4, 1927

and that death occurred, on the date stated above, at 12 55 P m

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. Culture

(Signed) Myron G. Sulle, M. D

10/5, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Oct 5 1927

20 UNDERTAKER H. Sonder Sons

ADDRESS 1710 Park

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26169

CERTIFICATE OF DEATH

75-001

E 26169

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 413 Mott St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Scott

(a) RESIDENCE NO. 413 Mott St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dennis Scott

6 DATE OF BIRTH (month, day, and year): Aug 22 1873

7 AGE: Years 54 Months 5 Days 10

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): West Va

(State or country)

PARENTS

10 NAME OF FATHER: unk

11 BIRTHPLACE OF FATHER (City or town): unk

(State or country)

12 MAIDEN NAME OF MOTHER: unk

13 BIRTHPLACE OF MOTHER (city or town): unk

(State or country)

14 Informant: Emily Noel

(Address) 413 Mott St

15 Filed ..... 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 19 27, to Oct 2 19 27

that I last saw her alive on Oct 2 19 27

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Cerebral

(duration) ..... yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

Oct 29 19 27 (Address) 508 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

Date of Burial: Oct 5 19 27

20 UNDERTAKER: Wm J. Gs Locke

ADDRESS 1302 Jeffer

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

CHAMPION JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

E 26170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66

E 26170

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) City Hospital St., 6-10 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Neff

(a) RESIDENCE NO. 126 Shroeder St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Neff

6 DATE OF BIRTH (month, day, and year) May 1st 1847

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	80	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER George Neff

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Interment George Neff

(Address) 1 N. Streeper

15 Filed....., 19 C. HARRISON JONES, M. D.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

*Ac Alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

Oct 7 1927 (Signed) G. C. Jones M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Oct 7th 1927

20 UNDERTAKER Frank V. Pipitone ADDRESS 2818 E. Baltimore St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26171
1-PLACE OF DEATH

129 ✓

E 26171
REGISTERED NO.

City of BALTIMORE. (No. 1306 Argyle St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas. E. Dennis

(a) RESIDENCE NO. 1306 Argyle av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa Dennis

6 DATE OF BIRTH (month, day, and year): Oct. 25, 1866

7 AGE: Years 60 | Months 11 | Days 7 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Md.

PARENTS

10 NAME OF FATHER: Jacob Dennis

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Mathews

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant: Louisa Dennis
(Address) 1306 Argyle av

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/2/27 19

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927 to Oct. 2, 1927 that I last saw him alive on Oct 2, 1927, and that death occurred, on the date stated above, at 2:05 P.M.

The CAUSE OF DEATH* was as follows:

Uremia
(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (secondary) Chronic nephritis
(duration) 4 yrs. 4 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) John H. Poppenheimer, M. D.

(Address) 1019 Druid Hill av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — Date of Burial 10/5 19 27

20 UNDERTAKER: Jno. M. Johnson — ADDRESS 1234 Ellwood Av

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26172

3 E 26172

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals 10.14 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Loesch

(a) RESIDENCE NO. 1025 N. Central ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Francois Loesch

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Kurse

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed , 19 Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 19 25, to Sept. 30, 19 27, that I last saw him alive on Sept. 30, 19 27, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows: Cardiac Dilatation

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) L. E. Meadows, M. D.

9-30, 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Sacred Heart	10/5 1927

20 UNDERTAKER J J Fahey Son ADDRESS 1318 Light St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26173

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26173

CERTIFICATE OF DEATH.

James J. Dunlap

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 10-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Dunlap

(a) RESIDENCE NO. 1032 N. Eden ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Mary Dunlap

6 DATE OF BIRTH (month, day, and year) Not Stated

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D C

PARENTS

10 NAME OF FATHER: Patrick J. Dunlap

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hannah Conroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Mary Dunlap

(Address) 1032 N Eden St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1927, to Oct 3 —, 1927, that I last saw h~~im~~ alive on Oct 3, 1927, and that death occurred, on the date stated above, at 2.40 p.m.

The CAUSE OF DEATH* was as follows:

Ulceration of Neck (Carbuncle) Streptococcis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? Yes Date of 9-24-27.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lawrence Fahnestock, M. D.

10/3/, 1927 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Oct 6 1927

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1301 E Eager St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26174 — 129 — REGISTERED NO. E 26174

1-PLACE OF DEATH

City of BALTIMORE: (No. 1351 Jackson St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Hill

(a) RESIDENCE NO. 1351 Jackson St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred Hill

6 DATE OF BIRTH (month, day, and year): Oct. 3, 1884

7 AGE — Years: 43 — Months: 0 — Days: 0

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Emmittsburg

(State or country): Md.

PARENTS

10 NAME OF FATHER: Anthony Coyle

11 BIRTHPLACE OF FATHER (City or town): unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Nurser

13 BIRTHPLACE OF MOTHER (city or town): Emmittsburg

(State or country) Md.

14 Informant: Alfred Hill

(Address) 1351 Jackson St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 1 19 27 to Oct. 3 19 27

that I last saw her alive on Oct. 3 19 27

and that death occurred, on the date stated above, at 5a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatitis Hepatitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allo Hayne M. D.

19 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer Cem	Oct 6, 27
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

E 26175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11 3 E 26175

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 709 N Stricker St., 11th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Hoff

(a) RESIDENCE NO. 709 N. Stricker St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 29, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		5 6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Lorraine Hoff

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Lorraine Hoff

(Address) 709 N. Stricker St

15 Filed . 19 Registrar

R.H.C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 19 27, to Oct 4, 19 27

that I last saw h. alive on Oct. 1, 19 27

and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

1 (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Summer Diarrhea

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) John G. Lainey M. D.

. 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — Date of Burial Oct 5, 1927

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26176

CERTIFICATE OF DEATH.

197 E 26176

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustav Lister Meyers

(a) RESIDENCE NO. 185 Potomac St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 22-1907

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	20	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer) Storage Co

(c) Name of employer Old Bay Line

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Chas. Myers

11 BIRTHPLACE OF FATHER (city or town)

(State or country) City

12 MAIDEN NAME OF MOTHER Nellie Meyers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) City

14 Informant (Address) C. L. Myers 185 Potomac St

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 — 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Gun Shot wound of Chest (duration) ..... yrs. ..... mos. 1 hr

CONTRIBUTORY (Secondary) Shock (duration) ..... yrs. ..... mos. 1 hr

Attended ..... (Address) 176 W Fayette St, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Date of Burial 10/5/ 1927

20 UNDERTAKER J. A. Moran ADDRESS 300 E. Baltimore

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26177

24-001

REGISTERED NO. E 26177

1-PLACE OF DEATH

City of BALTIMORE: (No. 12 E.Randall Street. St. 23-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Held

(a) RESIDENCE NO. 12 E.Randall Street. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. if of foreign birth 77 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Held

6 DATE OF BIRTH (month, day, and year) January 24,1854

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or....min..
	73	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Cabinet Maker

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

11 Informant Mrs Katherine Held

(Address) 12 E.Randall Street.

15 Filed ..... 19.... C. CHAMPION JONES, M. D. Registrar

per Rhyl

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3,1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1927, to Oct 3, 1927, that I last saw him alive on Oct 2, 1927, and that death occurred, on the date stated above, at 2 30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy -

(duration) yrs. mos. 10 ds.

CONTRIBUTORY Arterio-sclerosis

(Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hanlon M. D.

10/5, 1927 (Address) 6 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn Cemetery	Oct 6,1927 19

20 UNDERTAKER Joe Joerdens & Son ADDRESS 217 S.Paca St

OCT 5 - 1927

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26178

CERTIFICATE OF DEATH.

E 26178

1-PLACE OF DEATH [illegible] HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 26-27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Collier

(a) RESIDENCE NO. Fifth ave Colgate Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12 2 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Herman Collier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant [illegible] HOPKINS HOSPITAL.
(Address)

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1927, to Oct 4, 1927, that I last saw him alive on Oct 4, 1927, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY
(Secondary) —
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Colgate, Md.

Did an operation precede death? yes Date of Oct 4, 1927

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture & culture

(Signed) C. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL 10 6 1927

20 UNDERTAKER George J Ruth

ADDRESS 1735 Maryland Ave

Spec.—1-10-21—M&T—1500 Bks.

E 26179

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

W 4 E 26179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 Melrose ST. 26th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Agnes Clayton.

(a) RESIDENCE No. 912 2nd St. Canton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col.	Married.

5a If married, widowed or divorced (or) WIFE of Joseph Clayton

6 DATE OF BIRTH (month, day, and year) May 1-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer Mrs. J. Bayard Williams

9 BIRTHPLACE (city or town) (State or country) Charles Co. Md.

PARENTS

10 NAME OF FATHER Robert Hungerford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Adelaide Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Md.

14 Informant Joseph Clayton

(Address) 912 2nd St. Baltimore

15 Filed ..... 19.. Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 4, 1927, to Oct 5, 1927, that I last saw her alive on Oct 4, 1927, and that death occurred, on the date stated above, at 1 30/2 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, (Paralysis)

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. M. Learmonth M. D.

10/5 1927 (Address) Dundalk. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	10/9 1927

20 UNDERTAKER	ADDRESS
Robt. E. Williams	1515 McElderry St

This is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 26180

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 26180

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1423 N Milton Ave St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Rick

(a) RESIDENCE NO. 1423 N Milton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Rick

6 DATE OF BIRTH (month, day, and year): June 16-1865

7 AGE: Years 62 Months 3 Days 19 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

14 Informant Mr George Rick

(Address) 1423 N Milton Ave

15 Filed ..... 19 .....

1927 HAMPSON JONES M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 4 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 19 27, to Oct 2, 19 27,

that I last saw him alive on Oct 2, 19 27,

and that death occurred, on the date stated above, at 5:10 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia and cardiac decompensation

(duration) ..... yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Oct 6, 1927 (Address) 1317 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

Date of Burial: Oct 7 1927

20 UNDERTAKER: John Merrick

ADDRESS: 2008 Edgar

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 26181

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] St., 1-K Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Bryan

(a) RESIDENCE NO. 508 S. East [redacted] St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) [redacted]

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1921, to Oct. 2, 1927, that I last saw him alive on Oct. 2, 1927, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Immediate cause Cerebral Hemorrhage

Intermediate Cerebral Sclerosis

Antecedent Hypertension

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Sec

(Signed) C. Hilton Bryan, M. D.

19 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Commissioner of Health.

Per. Wm. F. [redacted]

OCT 5 - 1927

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26182

CERTIFICATE OF DEATH.

129 E 26182

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1712 Etting St. 14-20 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME James Johnston

(a) RESIDENCE NO. 1712 Etting St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Organist

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Father Husband (Address) 1532 Fremont Ave

15 Filed _____, 19____ Registrar [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1927, to Oct 5, 1927 that I last saw h[illegible] alive on Oct 5, 1927 and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH*, was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) _____

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Wildman Treat, M. D.

Oct 5, 1927 (Address) 1288 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Date of Burial Oct 8th 1927

20 UNDERTAKER [illegible] ADDRESS 1364 Park Ave

very important. See instructions on back of certificates.

JAMESON JONES M.D.

Spec.-7-17-26—A Co.—200 Bks.

E 26183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 26183

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4203 Springdale Ave St. 28-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ammer Weber

(a) RESIDENCE NO. 4203 Springdale Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl J. Weber

6 DATE OF BIRTH (month, day, and year) October 6, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	69	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER William Ammer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. Walter M. Weber

(Address) 1432 Harlem Avenue

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Oct 3, 1927, that I last saw her alive on Oct 1, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cardio-Failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis - Senile Regurg

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. W. Mayer, M. D.

10/4, 1927 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial 10/6/27 19

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Baltimore St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26184

CERTIFICATE OF DEATH.

11-E 26184

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 927 Bolton (St.) 11-24 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orlando A. Wilkinson Jr.

(a) RESIDENCE NO. 927 Bolton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Lena Hechter

6 DATE OF BIRTH (month, day, and year) June 28-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	55	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Commission

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Orlando A. Wilkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Lena Wilkinson (Address) 927 Bolton St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1927, to Oct. 4, 1927, that I last saw him alive on Oct. 4th, 1927, and that death occurred, on the date stated above, at 10 A m

The CAUSE OF DEATH* was as follows:

Gastric hemorrhage

CONTRIBUTORY (Secondary) (duration) Gastric ulcer yrs. mos 4 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry D. McCarty M. D.

(Address) 137 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gordon Park Cem. DATE OF BURIAL Oct 7 1927

20 UNDERTAKER Harry W. Ellis ADDRESS 1744 W. North Ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26185

CERTIFICATE OF DEATH.

113 E 26185

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1733 N. Gay St. 15-H Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Collins B. Standley

(a) RESIDENCE NO. 1733 N. Gay St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: color

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5, 1927

7 AGE Years 4 Months 7 Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Collins B. Standley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Myrtle Nichols

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Myrtle Standley

(Address) 1733 N. Gay St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4th 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... 2 days

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

12, 19 7 (Address) 75 N. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial 12-6 1927

20 UNDERTAKER: Mrs Chas G. Bailey — ADDRESS 1421 Hanover St

very important. See instructions on back of certificate

Spec.--1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26186 E 26186

CERTIFICATE OF DEATH.

REGISTERED NO. 76

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 25th WARD 23)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard M. Fuller

(a) RESIDENCE NO. Mt Hope Retreat ST. 28th WARD Bedford Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6th 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	34	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pharmacist

(b) General nature of industry, business, or establishment in which employed (or employer) Drug Business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bedford Pa

PARENTS

10 NAME OF FATHER Thomas J Fuller

11 BIRTHPLACE OF FATHER (city or town) Bedford (State or country) Pa

12 MAIDEN NAME OF MOTHER Ella Dively

13 BIRTHPLACE OF MOTHER (city or town) Bedford (State or country) Pa

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Baltimore

15 Filed ....., 19 ..... Registrar

C. EMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 12th, 1924, to Oct 4, 1927,

that I last saw h— alive on Oct 4, 1927,

and that death occurred, on the date stated above, at 11.00 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis with Convulsions

(duration) 3 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Paralytic Dementia

(duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Bedford Pa

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flaherty, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bedford Pa. DATE OF BURIAL Oct 6 1927

20 UNDERTAKER STEWART & HOOVER COMPANY (WILLIAM F. HOOVER, Secretary) ADDRESS 108 W. NORTH AVE.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26187

CERTIFICATE OF DEATH.

66 E 26187

1-PLACE OF DEATH

City of BALTIMORE: (No. 1462 Reynolds St. 24-25 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Sosnowski.

(a) RESIDENCE NO. 1462 Reynolds St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow.

5a If ~~XXXXXX~~ widowed, ~~XXXXXX~~ ~~XXXXXXXXXX~~ (or) WIFE of Michael Sosnowski.

6 DATE OF BIRTH (month, day, and year) September 10. 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland.

PARENTS

10 NAME OF FATHER Casmer Szymkewicz.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland.

14 Informant John Sosnowski. (son)

(Address) 1446 Reynolds St.

15 Filed_____, 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 4 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Charles Leonhardt M. D.

(Coroner)

10/5. 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death____ yrs.____ mos.____ ds. In the State____ yrs.____ mos.____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Date of Burial

Holy Cross Cem Co Oct 6 1927

20 UNDERTAKER ADDRESS

Chas M Weber 1923 Eastern Ave

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 26188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 26188

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 N. Curley (St.) 6-11 (Ward)

2-FULL NAME Kate Deron

(a) RESIDENCE NO. 111 N. Curley ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Deron

6 DATE OF BIRTH (month, day, and year) Apr 14 1868

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Joseph Geir

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lizzie Schuel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant Lizzie Deron

(Address) 111 N Curley St

15

Filed ..., 19...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

17

I HEREBY CERTIFY, That deceased from Aug 8, 1927, to Aug 3, 1927, that I last saw h[illegible] alive on Aug 2, 1927, and that death occurred, on the date stated above, at 6.55 a. m.

The CAUSE OF DEATH* was as follows:

Cyhosis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms

(Signed) Jas V O'Neill, M. D.

(Address) 2601 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	10/6/1927

20 UNDERTAKER J. A. Moran

ADDRESS 3000 E Balto

THON is very important. See instructions on back of certificates.

C. THOMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26189 E 26189

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3310 Tioga Parkway St. 28-41 (WARD)

2-FULL NAME Alice K. Wartman

(a) RESIDENCE NO. 3310 Tioga Parkway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1857

7 AGE: 69 Years | Months: 11 | Days: 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No paid occupation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER A. Charles Wartman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Kate Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Mrs. D. J. McGregor (sister)
(Address) 3310 Tioga Parkway

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from about 1 year ago 19 ..... to Oct. 5 1927.

that I last saw her alive on Oct. 5 1927.

and that death occurred, on the date stated above, at 3:45 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of axilla and lung.

(duration) about 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) C. T. O'Donnell, M. D.

Oct. 5 1927 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery | DATE OF BURIAL: Oct 7th 1927

20 UNDERTAKER: Putnam & Poe | ADDRESS: 1723 W. Lafayette

THIS IS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16- E 26190

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 26-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elie Cavinas

(a) RESIDENCE NO. 1108 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 3 1927

7 AGE: Years — Months 7 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry Cavinas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Celeste Cavinas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece.

14 Informant Harry Cavinas (Address) 4708 Eastern ave

15 Filed , 19 Registrar RK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 , 19 27 , to Sept 5 , 19 27 , that I last saw him alive on Oct 5 , 19 27 , and that death occurred, on the date stated above, at 5 15 PM m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) H Lawrence Johnny , M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn County — DATE OF BURIAL Oct 6 1927

20 UNDERTAKER Geo. J. Pfaff — ADDRESS 1735 Harford ave.

Spec.—1-10-21—M&T—1500 Bks.

E 26191

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26191

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. WARD) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey Smith.

(a) RESIDENCE NO. 1 Ace Road ST., WARD Elkridge
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: Colored — 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Emma Smith

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE: Years 55 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hurlock Md

PARENTS
10 NAME OF FATHER: Henry Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Rebecca Jackson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Records. (Address)

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-4 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-3, 1927, to 10-4, 1927, that I last saw him alive on 10-4, 1927, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Peritonitis - Causative organism probably Pneumococcus - to be determined (duration) yrs. mos 14 ds.
CONTRIBUTORY (Secondary) Myocardial degeneration (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of 10-3-27
Was there an autopsy? No
What test confirmed diagnosis? Operation.
(Signed) Paul M. Hall, M. D.
, 19 (Address) Franklin Sq. Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. — DATE OF BURIAL: Oct 6 1927

20 UNDERTAKER: Samuel A. Stanley — ADDRESS: 78 N. Eddy St.

Fill in very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

139

E 26192

CERTIFICATE OF DEATH

E 26192

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Colonial Hospital St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Blackwell

(a) RESIDENCE NO. 1128 Druid Hill Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colred

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Blackwell

6 DATE OF BIRTH (month, day, and year): Sept 16, 1885

7 AGE — Years: 42 Months: 0 Days: 17

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va

PARENTS

10 NAME OF FATHER: John Hunt

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): ?

14 Informant: Mrs Blackwell

(Address): 1125 Druid Hill Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 30 1927, to Oct 3 1927, that I last saw h[illegible] alive on Oct 3 1927, and that death occurred, on the date stated above, at 1150 p. m.

The CAUSE OF DEATH* was as follows: Uterine fibroid

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Shock

(duration) yrs. 1 mos. ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? Yes Date of Oct 3, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Clin. data

(Signed) [illegible], M. D.

, 19 (Address) 3034 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. Date of Burial Oct 6 19 27

20 UNDERTAKER: Samuel Hemsley ADDRESS Mt Eddie

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26193

CERTIFICATE OF DEATH.

101-001

E 26193

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 517 S. Dallas St. (St.) 3-4 (Ward)

2-FULL NAME Albert Telewicz

(a) RESIDENCE NO. 517 S Dallas St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27-27

7 AGE: Years — Months 5 — Days 26 — If LESS than 1 day, hrs. or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Albert P. Telewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Sophie Lampka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant A. P. Telewicz

(Address) 517 S Dallas St

15 Filed ..... 19 .....

Per R.M.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1927, to Oct 6, 1927, that I last saw h— alive on Oct. 5, 1927, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Bilat

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Jaruzeski M. D.

10/ 1927 (Address) 2431 Fait Av

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Oct 6 - 27 — DATE OF BURIAL 19

20 UNDERTAKER: F. W. Ozazewski — ADDRESS 1930 Eastern Av

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26194

CERTIFICATE OF DEATH.

129 E 26194

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 N. Carey ST. 16 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Henson Jr.

(a) RESIDENCE NO. 1117 N. Carey ST. 16 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A. Henson

6 DATE OF BIRTH (month, day, and year) January 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Louis Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Caroline Mason

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant [illegible] (Address) [illegible]

15 Filed [illegible] 1927 Registrar RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/3/1927

17

I HEREBY CERTIFY, That I attended deceased from 9/27/1927, to 10/3/1927, that I last saw him alive on 10/3/1927, and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation.

Pulmonary Hypostasis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical History

(Signed) W. W. Bishop, M. D.

, 19 (Address) 709 Haven St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct 6 1927
20 UNDERTAKER John W. Toadvine	ADDRESS 1127 Pine St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26195

CERTIFICATE OF DEATH.

E 26195

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 23-34 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Virginia Vendouern

(a) Residence No. 19 E. Heath St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred allher life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 5 1894

7-AGE, 33 yrs. 2 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James W. Stanley Sr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary L. Homberger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mr Geo Vendouern

(Address) 19 E. Heath St.

15-

Filed 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10/3/27

17- I HEREBY CERTIFY, That I attended deceased from 9/29 19 27 to 10/3 19 27

that I last saw h alive on 10/3 19 27

and that death occurred, on the date stated above, at 2.55 a m.

The CAUSE OF DEATH* was as follows:

Placenta Previa with uterine hemorrhage

(Duration) yrs. mos. 2 weeks

CONTRIBUTORY (Secondary) Surgical Shock. Peritonitis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/29/27

Was there an autopsy? Yes

What test confirmed diagnosis? Physician. Operation Autopsy

(Signed) Knight Reynolds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loud Hill Cem. Oct. (or Nov.) 192

DATE OF BURIAL,

20-UNDERTAKER, F. A. Wamsley

ADDRESS 703 Hamm

E 26196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 26196

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital 14-20 Ward)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Francis Tallmer

(Residence in Baltimore: No. 1401 Dimison St. St.; yrs. 6 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced (Write the word.): Single

6-DATE OF BIRTH: March (Month) 19 (Day) 22 (Year)

7-AGE: ... yrs. 6 mos. 16 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE (State or Country): Maryland

PARENTS:

10-NAME OF FATHER: William Tallmer

11-BIRTHPLACE OF FATHER (State or Country): Wisconsin

12-MAIDEN NAME OF MOTHER: [illegible] Reimer

13-BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

St Vincent Infant Asylum Record

(Address) 1401 Dimison St

15-

Filed ... 192...

[illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: ... (Month) Dec 4 (Day) 27 (Year) 192...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition-Acute Gastro-intestinal indigestion.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. Leigh Allen (Coroner.) M. D.

12/5/27 192... (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer DATE OF BURIAL: 12-6-27

20-UNDERTAKER: Mattie Foley Sr ADDRESS: 1820 W [illegible]

Spec.—1-10-21—M&T—1500 Bks.

E 26197

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 26197

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 N. Gay ST. 5-X WARD)

2-FULL NAME Joseph H. Burke

(a) RESIDENCE NO. 235 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Burke

6 DATE OF BIRTH (month, day, and year): Sept 22 1872

7 AGE — Years: 55 — Months: — Days: 13 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: City - Balto.

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: George Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mary E. Burke

(Address): 235 N. Gay St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1927, to Oct 5, 1927.

that I last saw h[illegible] alive on Oct. 5, 1927

and that death occurred, on the date stated above, at 4 A[illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert F. Green M. D.

10-5-1927 (Address) 120 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem

DATE OF BURIAL: Oct 7 1927

20 UNDERTAKER: Emily Lewis

ADDRESS: [illegible]

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

26 26198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 E 26198

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 17-50 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Shelton

(a) RESIDENCE NO. 2454 Buchanan St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Perry Shelton

6 DATE OF BIRTH (month, day, and year) Unknown 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
35				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joshua Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Louise Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address)

15 Filed ..... 19 ..... R W L Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1927, to Oct. 3, 1927, that I last saw her alive on Oct. 3, 1927 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Appendicitis, acute, ruptured
generalized peritonitis
septicaemia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-1-27

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. K. Lemon M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Oct 6 1927

20 UNDERTAKER Mrs R. G. Elliott — ADDRESS 1725 Eastland Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26199

CERTIFICATE OF DEATH.

E 26199

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 1 E. ST., 26 WARD)

REGISTERED NO. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Fredenck

(a) RESIDENCE NO. 114 S - 8th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-2-26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	16 5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank Fredenck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Florence Stachowska

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed ..., 19... Registrar RHK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1927, to Oct 4, 1927, that I last saw her alive on Oct 4, 1927, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Entero colitis

(duration) yrs 1 mos ds

CONTRIBUTORY (Secondary) Congenital syphilis

(duration) yrs 16 mos ds

18 Where was disease contracted if not at place of death? 1145 S 8th St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J C Goodwin M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Oct 6, 1927.

20 UNDERTAKER M J. Sadowski ADDRESS 705 S Wolfe St

Spec.—1-12-23—M&T—500 Blks.

E 26200

HEALTH DEPARTMENT—CITY OF BALTIMORE E 26200

CERTIFICATE OF DEATH. 185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. B. & Hospital St. 1668 WARD)

REGISTERED No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Crum

(a) RESIDENCE No. Laurel Md ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	white	~~S~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Crum

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R.R

9 BIRTHPLACE (city or town) (State or country) Oakland Md. Garrett Co. Md

PARENTS

10 NAME OF FATHER George Crum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Garrett Co. Maryland

12 MAIDEN NAME OF MOTHER Miss Corbett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant [illegible]
(Address) [illegible]

15 Filed , 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5/1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 19 27, to Oct 5, 19 27, that I last saw him alive on Oct 5, 19 27 and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Myocarditis Toxemia

(duration) yrs. mos 2nd ds.

CONTRIBUTORY (Secondary) Acute Colitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Feldman, M. D.

, 19 (Address) West Baltimore & Stricker

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md — DATE OF BURIAL Oct 10th 1927

20 UNDERTAKER Edward F Fisher ADDRESS Laurel Md

Spec.–7-17-26—A Co.—200 Bks.

E 26201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 26201

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1911 Gough St., 2nd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Depro.

(a) RESIDENCE NO. 1911 Gough St. 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 11th 1866

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	61	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Augustus Depro

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Phoenix

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Edw. H. Lilly

(Address) 403 S. Wolfe St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/27, 1927, to 10/4, 1927

that I last saw her alive on 10/4, 1927

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

(Acute Organic Nephritis
Kidney Regulation

(duration) yrs. mos. 9t ds.

CONTRIBUTORY (Secondary) Infantile Paralysis & Cellulitis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Jay A. Rumbolt, M. D.

(Address) 1623 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mount Carmel Cem	Oct 7th 1927
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

E 26202

CERTIFICATE OF DEATH

REGISTERED NO. E 26202

1-PLACE OF DEATH 3140 Fait ave

City of BALTIMORE: (No. ____ St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Flynn

(a) RESIDENCE NO. 3140 Fait ave St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 8 mos. 14 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Patrick H. Flynn

6 DATE OF BIRTH (month, day, and year): Jan. 21, 1863

7 AGE: Years 64 Months 8 Days 14 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Jacob Lightner

11 BIRTHPLACE OF FATHER (City or town): ____

(State or country): Germany

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town): ____

(State or country): Germany ?

14 Informant: Mrs. Lawrence Flynn

(Address): 3140 Fait ave

15 Filed ____ 19 ____ Registrar

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 5th - 27.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to Oct. 5, 1927, that I last saw h[illegible] alive on Oct 5, 1927 and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis & Arterio Sclerosis - Chronic Nephritis and Generalized arteriosclerosis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Joseph Toohey, M. D.

, 19 28 (Address) South Eldon ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Oct 8 1927

20 UNDERTAKER: Lilly & Linn — ADDRESS: 403 S. Wolfe St

Cor.—12-9-25—A Co.—200 Bks.

26203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-001

E 26203

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Enroute to St. Joseph Hospital St. 16-18 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J. Geller

(a) RESIDENCE NO. 2503 Calverton Hts Av St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) March 4/1904

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	23	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman 13 01

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Chas A. Geller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Kline

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Chas. A. Geller

(Address) 2503 Calverton Hts Ave

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Hemorrhage, Crushed right abdomen, region of groin. Accidently caught while coupling car nr Lorley, Md. (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Jos. Wall M. D.

(Coroner)

10-5-27, 19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial Oct 7 1927

20 UNDERTAKER Robt J Turner & Co ADDRESS 1343 A Broadway

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26204

CERTIFICATE OF DEATH.

26204

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. South Balto Gen Hospital) St. (Ward)

2-FULL NAME Albert C Gilbert

(a) RESIDENCE NO. 1641 Montpelier St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Albert M. Gilbert

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J Jenkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Ella Gilbert

(Address) 1641 Montpelier St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1927 19

17

I HEREBY CERTIFY, That I attended deceased from Sept 2, 1927, to Oct 3, 1927, that I last saw h.. alive on Oct 3, 1927, and that death occurred, on the date stated above, at 12 o'clock m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix of Uterus Surg Hem

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism

Right Lung (duration) yrs. mos. 3 hrs

18 Where was disease contracted

If not at place of death

Did an operation precede death? Yes Date of Oct 3/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. A. C. Wasson, M. D.

, 19 (Address) 839 Wilson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

London Park Cemetery — Oct 7 1927

20 UNDERTAKER — ADDRESS

Robt J Turner & Son — 1002 E Broadway

very important. See instructions on back of certificate.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26205

CERTIFICATE OF DEATH

49 E 26205

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay City Hospital St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Poslon

(a) RESIDENCE NO. 1200 E Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 49 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Indiana

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Indiana

14 Informant

(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-19-, 1927, to 10-3, 1927

that I last saw him alive on 10-3, 1927

and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows: Pneumonia & pleurisy and Carcinoma ?

(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathological Examination

(Signed) W Blanford, M. D.

. 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial , 19

20 UNDERTAKER — ADDRESS

very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

OCT 6 - 192

1264 2000

Spec.–7-17-26—A Co.—200 Bks.

Mary Wrenn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26206

CERTIFICATE OF DEATH

90 E 26206

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 23-31 Ward) BALTIMORE CITY HOSP

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wrenn

(a) RESIDENCE NO. 222 W. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) ?

PARENTS

10 NAME OF FATHER Ed. Wrenn

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Emaline ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant BALTIMORE CITY HOS

(Address) [redacted]

15 Filed ..... 19 .....

Registrar

1765 RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1922 to Oct. 3, 1922, that I last saw h[illegible] alive on Oct. 3, 1922, and that death occurred, on the date stated above, at 11:20 A.m.

The CAUSE OF DEATH* was as follows:

Intussusception during acute catharsis and intestinal obstruction

(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms

(Signed) C. J. Holmes M.D.

, 19 (Address) CITY HOS

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND.

OCT 6 - 1922

Commissioner of Health.

Asst. Reg. E. W. SMALL

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26207 716

E 26207

CERTIFICATE OF DEATH.

70

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... Johns Hopkins Hospital ST., 1 WARD)

2-FULL NAME John Smith

(a) RESIDENCE NO. 2212 Boston ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-7-27

7 AGE — Years ..... Months 2 Days 28 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Vernon Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Resides Johns Hopkins Hospital

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5, 1927.

17

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1927, to Oct 5, 1927, that I last saw him alive on Oct 5, 1927 and that death occurred, on the date stated above, at 12:35 a m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? 2212 Boston St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C C Guthrie, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. — DATE OF BURIAL Oct. 6 - 1927

20 UNDERTAKER M. J. Sadowski. — ADDRESS 705 S. Ann St.

Spec.-7-17-26—A Co.—200 Bks.

E 26208

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 26208

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Calvert Court Apartments St. 12-D Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Adeline Goddard

(a) RESIDENCE NO. Calvert Court Apartments St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eugene H. Goddard

6 DATE OF BIRTH (month, day, and year) Aug. 17, 1843

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	84	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Illinois

PARENTS

10 NAME OF FATHER Jesse Burgess Thomas

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Adeline C. Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Y. City

14 Informant Louise E. Goddard

(Address) Calvert Court Apts.

15 Filed ..., 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 19 27

17 I HEREBY CERTIFY, That I attended deceased from ..., 19 26, to 10-6, 19 27,

that I last saw h[illegible] alive on 10-5, 19 27,

and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:

CEREBRAL HEMORRHAGE

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

, 19 (Address) 1129 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New London, Conn.

Date of Burial Oct. 19 27

20 UNDERTAKER John C. Mitchell & Son

ADDRESS [illegible]

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26209

CERTIFICATE OF DEATH.

90 E 26209

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1505 E. Madison St St., 7-13 Ward)

2-FULL NAME Mary Walker

(a) RESIDENCE NO. 1505 E.Madison St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. ___ mos. ___ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Walker

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) N.C.

PARENTS

10 NAME OF FATHER Aaron George

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) N.C.

12 MAIDEN NAME OF MOTHER Delphanie Curd

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) N.C.

14 Informant Henry Walker

(Address) 1505 E. Madison St

15 Filed_____, 19____ RPA Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Incompetency - probably vascular

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. C. Wallace, M. D.

(Coroner)

10/6/27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Osborn Cemetery Date of Burial Oct 9 1927

20 UNDERTAKER Robert T. Williams ADDRESS 1515 N. Eden Alley

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26210

CERTIFICATE OF DEATH.

E 26210

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hos Dalat St. 24-34 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Donovan

(a) RESIDENCE NO. 13-01 Light St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 51 Months about Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant W. J. Flynn

(Address) 639 Broadway

15 Filed....., 19.....

ARH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

(Signed) W. J. Flynn (Coroner) M. D.

Oct 6, 1927 (Address) 1927 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Margaret T. Flynn Date of Burial: Oct 7 1927

20 UNDERTAKER: Body Cross & Co. ADDRESS: 1422 Light.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26211

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Lawrence St. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Price

(a) RESIDENCE No. 523 N. Lawrence ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Unknown

6 DATE OF BIRTH (month, day, and year) Feb 24, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid & Waitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) U/

12 MAIDEN NAME OF MOTHER U

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U/

14 Informant Ruth Gordon (Address) 523 N. Lawrence St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Oct 4, 1927, that I last saw her alive on Oct 3, 1927, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Heart trouble

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. Lee Elza, M. D.

Oct 4, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Oct 7 1927

20 UNDERTAKER Daniel Easterday — ADDRESS 916 Eager

Spec.—12-9-25.—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26212

CERTIFICATE OF DEATH.

90 E 26212

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. German Aged Home St. 90-27 Ward)

2-FULL NAME Mary A. Klinefelter

(a) RESIDENCE NO. German Aged Home St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr Known

6 DATE OF BIRTH (month, day, and year): March 17 1850

7 AGE — Years: 77 — Months: 6 — Days: 24 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Brooklyn

(State or country): U.S.A.

PARENTS

10 NAME OF FATHER: Samuel Yost

11 BIRTHPLACE OF FATHER (city or town): Ellicott

(State or country): New York

12 MAIDEN NAME OF MOTHER: Augusta Henry

13 BIRTHPLACE OF MOTHER (city or town): Middleton

(State or country): Md.

14 Informant: German Aged Home

(Address) Gaith & Payson Sts

15 Filed ..... 19 .....

Registrar

0004

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 6th 19 27

17

I HEREBY CERTIFY, That I attended deceased from 1924 19 ..... to Oct 6th 19 27, that I last saw h.. alive on Oct 5th 19 27, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John D. Cook M. D.

19 (Address) 1843 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial Oct 8 1927

20 UNDERTAKER: Dep M Cook — ADDRESS 1603 N Gaith St

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Frick)

E 26213

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 Fench Drive ST., 27-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo J Frick

(a) RESIDENCE NO. 112 Fench Drive ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX (Male)

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Frick

6 DATE OF BIRTH (month, day, and year) April 25 1844

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
83	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookbinder

(b) General nature of industry, business, or establishment in which employed (or employer) retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14

Informant (Address) Geo W Frick 1700 Appleton St

15

Filed . 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4th 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 4 . 1927 to Oct 4 . 1927 .

that I last saw h alive on Oct 4 . 1927 ,

and that death occurred, on the date stated above, at 1145 m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

Arteriosclerosis

(duration) yrs. mos ds

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Semmes M. D.

(Address) 4 W Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 7 1927

20 UNDERTAKER: Nathan Cook — ADDRESS: 502 E Madison

TION IS very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26214

CERTIFICATE OF DEATH.

E 26214

1-PLACE OF DEATH

City of BALTIMORE: (No. Catonsville Home St. 27-55 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. E. Bopp

(a) RESIDENCE NO. 324 Winans St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of Laura Bopp.
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 6 1865

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	59	3	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Dunham Corp

9 BIRTHPLACE (city or town) Monktown
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Bopp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ger

12 MAIDEN NAME OF MOTHER Sarah McKenney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Richmond

14 Informant Laura Bopp
(Address) 324 Winans St

15 Filed....., 19.....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBITORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State yrs.. mos.. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Oct 8 1927

20 UNDERTAKER H. Cook ADDRESS 372 Hanover

very important. See instructions on back of certificate.

E 26215

1 PLACE OF DEATH

County

49 E 26215

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

Village or City Baltimore (No. 3029 E Baltimore St. Ward) 1 W

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles H Burtschen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Aug. (Month) (Day) 1867 (Year)

7 AGE 60 yrs. 2 mos. ds. If LESS than 1 day hrs. or min.

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed or (employer) Manf.

9 BIRTHPLACE (State or country) Ohio

PARENTS

10 NAME OF FATHER Nicholas Burtschen

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Susan Bland

13 BIRTHPLACE OF MOTHER (State or country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas H. Burtschen

(Address) 3029 E Balto St

15 Filed 192 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 4 (Month) (Day) , 1927 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 1927 to Oct 4 , 1927.

that I last saw him alive on Oct 4 , 1927.

and that death occured on the date stated above, at 1130 p m.

The CAUSE OF DEATH * was as follows:

Carcinoma Bladder

(Duration) 1 yrs. 4 mos. ds.

Contributory Secondary Carcinoma

(Duration) 1 ½ yrs. mos. ds.

(Signed) R. O. Carman M. D.

Oct 5 1927 (Address) 1201 N Carolina St

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 7 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Ho Redeemer

DATE OF BURIAL Oct 7 , 1927

20 UNDERTAKER J. J. Nolan

ADDRESS E Balto St

If more blanks are needed, address State Registrar, 16 E. Saratoga St., Balto., Requesting V. S. f.o. 1.

E 26216

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Alban Hotel

CITY OF BALTIMORE (No. Cathedral & Read St. 11-24 Ward) REGISTERED No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Randall Ball

(Residence in Baltimore: No. Cathedral & Read St. 75 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Unknown, 1 .....
(Month) (Day) (Year)

7-AGE, about 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Walter Ball

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Nellie Ford

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. R. Ridgely

(Address) Hotel Renaut

15-

Filed ....., 191.....

R P M Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilation

Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Oct 6, 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Auburn Cemetery	Oct 7, 1917
20-UNDERTAKER	ADDRESS
Harry Jenkins Sons	1500 Eutaw St

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 26217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26217

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2916 St Paul St (ST.) 12-50 (WARD)

2-FULL NAME Henry. C. Campen

(a) RESIDENCE NO. 2916 St Paul St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~
HUSBAND of
~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Sept 25th 1853

7 AGE: Years 74 | Months | Days 11 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work..... Retired Mfr
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John C. Campen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Caroline Rudick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant H. A. Campen
(Address) 2916 St Paul St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1924, to Oct 6th, 1927, that I last saw her alive on Oct 6th, 1927 and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. A. Chenard M. D.

Oct 8th, 1927 (Address) 130 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairmount Cem. | DATE OF BURIAL: Oct 8th 1927

20 UNDERTAKER: Chas. H. Jenkins Sons Co. | ADDRESS: Baltimore & Mt. Holly Sts.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26218

E 26218

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 E Fayette ST., 5-8 WARD)

2-FULL NAME Ida Berlin

(a) RESIDENCE NO. 1218 E Fayette ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 34 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Harry Berlin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... Russia
(State or country)

PARENTS

10 NAME OF FATHER Harry Berlin

11 BIRTHPLACE OF FATHER (city or town) ... Russia
(State or country)

12 MAIDEN NAME OF MOTHER Hanna Berlin

13 BIRTHPLACE OF MOTHER (city or town) ... Russia
(State or country)

14 Informant Hyman Berlin
(Address) 1218 E Fayette St

15 Filed ..., 19 ... Registrar

R.K.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6th 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept-e, 19 21, to Oct 6th, 19 27,

that I last saw h✓ alive on Oct 6th, 1927

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diaguosis?

(Signed) J. J. [illegible], M. D.

Oct 7, 1927 (Address) 1218 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern ave

DATE OF BURIAL Oct 7 1927

20 UNDERTAKER S Levenson Bro

ADDRESS 1217 E Balto St

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26219

113 E 26219

1-PLACE OF DEATH

City of BALTIMORE: (No. 1309 Holbrook St., 9-18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Peters

(a) RESIDENCE NO. 1309 Holbrook St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 1 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 4 1927

7 AGE — Years: — Months: 3 Days: 1 IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Albert J. Peters

11 BIRTHPLACE OF FATHER (City or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna M. Adams

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. Albert J. Peters

(Address) 1309 Holbrook St

15 Filed ... 19 ... RKK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 19 27 to Oct. 5 19 27

that I last saw her alive on Oct. 5 19 27

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-interitis

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Levin Wagner M. D.

1106, 1927 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Oct. 7 1927

20 UNDERTAKER: Henry Hoeck & Son — ADDRESS: 1301 E. Eager St

very important. See instructions on back of certificates. Property classified. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26220

CERTIFICATE OF DEATH.

40 E 26220

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 16-41 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jessie Stocksdale

(a) RESIDENCE NO. 3. Valley View Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 20 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	7	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alpheus Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Ella Ginavan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore - Md.

14 Informant Hospital Records.
(Address) St Joseph Hospital

15 Filed , 19 CKK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1927, to Oct. 6, 1927, that I last saw her alive on Oct 6, 1927, and that death occurred, on the date stated above, at 12:29 m.

The CAUSE OF DEATH* was as follows:

Chr. Salpingitis & Oophoritis
Inflamation of sigmoid Colon
& Rectum.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 9/30/27

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) T. P. Thompson, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 8 1927

20 UNDERTAKER Chenoweth Son

ADDRESS 3615 Chestnut Ave

Spec.—1-12-23—M&T—500 Blks.

E 26221 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26221

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 Glenwood Ave. WARD) 13-57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian May Dulaney.

(a) RESIDENCE NO. Joppa Road. Fullerton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 8, 1924

7 AGE: Years 3 | Months 0 | Days 28 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Grafton Dulaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ollie Pritchard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Grafton Dulaney (Address) Joppa Road Fullerton

15 Filed ..., 19 ... Registrar RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6, 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 5th, 19 27, to Oct 6th, 19 27,

that I last saw h Lr alive on Oct 5th, 19 27,

and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Illeo-colitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Worked Septicemia Poisoning

Convulsions (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Pillsbury, M. D.

Oct 6, 19 27 (Address) 3615 Foster Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary. Hampden — DATE OF BURIAL: Oct 8 1927

20 UNDERTAKER: Thenowerth Son — ADDRESS: 3615 Eastern Ave

Spec.—12-9-25—A Co.—200 Bks.

Gershon Hudles

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 ✓

E 26222

1-PLACE OF DEATH

REGISTERED NO. E 26222

City of BALTIMORE: (No. Sinai Hospital St., 15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gershon Hudles

(a) RESIDENCE NO. 1632 N Smallest St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minna Hudles

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE: 46 Years — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia (State or country)

PARENTS

10 NAME OF FATHER: Morris Hudles

11 BIRTHPLACE OF FATHER (city or town): (State or country) Russia

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Russia

14 Informant: Jack Lewis (Address) 1439 E Balt St

15 Filed....., 19..... Registrar

R.R.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10-6-27.

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1927, to Oct 6, 1927, that I last saw h alive on 2.30 PM, 1927 and (that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH* was as follows:

Cardiac failure - Arteriosclerosis

(duration) yrs. mos. One ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) yrs. One mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Fulton Sherry, M. D.

10/6 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel Date of Burial 10/7 1927

20 UNDERTAKER: Jack Lewis ADDRESS 1439 E Balt St

very important. See instructions on back of certificates.

Spec.—1-10-21 - M&T—1500 Bks.

E 26223 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 E. Hoffman ST., 8 WARD) 8-17 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Anna Guidice

(a) RESIDENCE No. 1504 E. Hoffman ST., WARD 8

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 0 mos. 13 ds. How long in U. S., if of foreign birth? 30 yrs. 0 mos. 8 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul O. Guidice

6 DATE OF BIRTH (month, day, and year) Sept 22 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John H Ludwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Virginia Hendricks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Paul C Guidice

(Address) 1504 E Hoffman St

15 Filed OCT 7 - 1927 19 RKK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1926 to Oct 5 1927

that I last saw her alive on Oct. 14 1927

and that death occurred, on the date stated above, at 7-45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Howard C. Silver, M. D.

19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Immanuel Cemetery

DATE OF BURIAL 10/8 1927

20 UNDERTAKER Louis Neumann

ADDRESS 3rd & Gay

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Appersen

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26224 ✓ E 26224

X 114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Emanuel Sanitarium Asylum

REGISTERED NO. C

CITY OF BALTIMORE: (No. Frederick Road ST. 28-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary A Appersen

(Residence in Baltimore: No. Emanuel Sanitarium Fred. Road St.; Asylum yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. (Month) 30 (Day), 1862 (Year)

7-AGE, 65 yrs. — mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired Grocer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, William Appersen

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Lottie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Woody

(Address) Richmond Va

15-

Filed....., 191.... .....Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1917, to Oct 6 1917, that I saw h e alive on Oct 6 1917, and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic Interstitial Nephritis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(Duration) yrs. two mos. ds.

(Signed) Alfred J Connelly M. D.

Oct 24, 1917. (Address) 1614 Fred. Rd Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 7 mos. 21 ds. In the State yrs. 7 mos. 21 ds.

Where was disease contracted, if not at place of death? Home Richmond Va

Former or usual residence Richmond Va

19-PLACE OF BURIAL OR REMOVAL, Richmond Va — DATE OF BURIAL, Oct ..., 1917

20-UNDERTAKER John C. Whitehead & Sons — ADDRESS 1600 Eutaw Place

Spec.—5-10-12—M. & T.—500 Bks.

E 26225

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 26225

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 W. Lanvale St. WARD) 46-22

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anaca Taylor

(Residence in Baltimore: No. 1518 W. Lanvale St.

St., 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH. October ? (Month) (Day), 1862 (Year)

7-AGE. 65 yrs. ? mos. ? ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER. Henry Rowe

11-BIRTHPLACE OF FATHER (State or Country). N. Carolina

12-MAIDEN NAME OF MOTHER Alice Rowe (Maiden Name)

13-BIRTHPLACE OF MOTHER (State or Country). N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth West.

(Address) 1518 W. Lanvale St.

15-

Filed ..... 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October (Month) 6 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 14 1927, to October 6 1927, that I saw her alive on October 5 1927, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis,
General.

(Duration) 2 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Acute Broncho-pneumonia (Duration) 0 yrs. 0 mos. 21 ds.

(Signed) John L. Stansbury M. D.

Oct. 7, 1927 (Address) John L. Stansbury 1637 E. Monument St.

*State the DISEASE CAUSING DEATH, or, IN DEATHS FROM VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Zion

DATE OF BURIAL. Oct. 8, 1927

20-UNDERTAKER Wm. R. A. Elliott

ADDRESS 125 Castleman

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26226

CERTIFICATE OF DEATH

46

E 26226

1-PLACE OF DEATH

City of BALTIMORE: (No. ____ St., [illegible] Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Wheeler

(a) RESIDENCE NO. 1012 Bryant St. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White Black

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 47 Months ____ Days ____ IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) ____ (State or country) Md.

PARENTS

10 NAME OF FATHER Charley Spencer

11 BIRTHPLACE OF FATHER (City or town) ____ (State or country) Virg.

12 MAIDEN NAME OF MOTHER Catherine Lyle

13 BIRTHPLACE OF MOTHER (city or town) ____ (State or country) Virg.

14 Informant ____ (Address) [illegible]

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/10/27, 19____, to 10/5, 1927, that I last saw h[illegible] alive on 10/5, 1927, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows: (Primary) Pneumonia, Influenza

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? London

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — Date of Burial 10/7 1927

20 UNDERTAKER Detrick Fields — ADDRESS 1200 N Eutaw

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26227

1-PLACE OF DEATH

City of BALTIMORE: (No. Washington Monument St., 15-21 Ward) 172 V

REGISTERED No. E 26227

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry L. Gilmore

(a) RESIDENCE NO. 1925 N. Wash-ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 13. 1896

7 AGE — Years: 30 — Months: 11 — Days: 22 — IF LESS than 1 day ..... hrs. or ..... min.: 24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Furniture

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER: Jacob Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Mrs. Harry Gilmore 1925 N Wash

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by Washington Monument-

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Dels. (Signed) W. H. Peters M. D.

(Coroner)

, 19 27 (Address) 1027 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — Date of Burial: 10/7 1927

20 UNDERTAKER: Grant H. Powell — ADDRESS: Pikesville Md

very important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26228 | 26228

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2536 Robb St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mone Kahl

(a) Residence No. 2536 Robb St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 10-2-27

7-AGE. ..... yrs. ..... mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: baby

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Arthur Kahl

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Brenda Mockabee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Washington DC

14- (Informant) Arthur Kahl

(Address) 2536 Robb St

15- Filed ..... 192 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 10-6-27

17- I HEREBY CERTIFY, That I attended deceased from 10-2 1927 to 10/6 1927

that I last saw her alive on 10-6 1927

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Patent Foramen Ovale &

Asphyxia Neonatorum

(Duration) ..... yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis Degeneration

(Duration) ..... yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) David Miller M. D.

10/6 1927 (Address) 1500 Bdway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 7 1927

20-UNDERTAKER: George J Smith — ADDRESS: 1532 Harlem Ave

Spec.—1-12-23—M&T—500 Blks.

E 26229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26229

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 210 W. Monument St

CITY OF BALTIMORE: (No. Hotel Sherwood ST. 11-2 WARD)

2-FULL NAME Annie Potter Kidder

(a) RESIDENCE NO. Hotel Sherwood ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug — 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	76	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wilmington N. C.

PARENTS

10 NAME OF FATHER Edward Kidder

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. H.

12 MAIDEN NAME OF MOTHER Anne Potter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilmington N. C.

14 Informant Geo. E. Kidder

(Address) Wilmington N. C.

15 Filed ..., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 , 1927 , to Oct 6 , 1927 , that I last saw h(r) alive on Oct 6 , 1927 and that death occurred, on the date stated above, at 1 8 m.

The CAUSE OF DEATH* was as follows:

Thrombosis Coronary Artery (duration) Hrs mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris (duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Heart Examination

(Signed) Hiram Quesler M. D.

Oct , 19 27 (Address) 806 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington N. C.

DATE OF BURIAL Oct 7th 1927

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS McClellan & Orchard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26230

CERTIFICATE OF DEATH.

113 E 26230

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 333. South 13th ST. [illegible] WARD.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Florence Rosie Larson

(a) RESIDENCE. No. 333. South 13th ST., 26 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26th 1927

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Edward Larson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Ann Frensch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Charles E. Larson
(Address) 333 S. 13th st.

15 Filed [illegible], 19[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6th 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 5th 1927, to Oct 6th 1927.

that I last saw her alive on Oct 5th 1927.

and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod. M. D.

19 (Address) 4700 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Oct 8th 1927

20 UNDERTAKER Lilly + Zeiler

ADDRESS 4038 Wash Ave

OCT 7 - 1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26231

CERTIFICATE OF DEATH.

E 26231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 W. Lexington St. ST. 19-27 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Buck Jigetts

(a) RESIDENCE No. 1635 W. Lexington St. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Negro.	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Louise Jigeets

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	73	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Station Porter

(b) General nature of industry, business, or establishment in which employed (or employer): B.O. RR

(c) Name of employer: B and O. RR

9 BIRTHPLACE (city or town) (State or country): Mecklenberge Co. Va.

PARENTS

10 NAME OF FATHER: Edward Jigetts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mecklenberge Co. Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Louise Jigetts (Wife)
(Address): 1635 W. Lex. ST.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6th, 1927

17

I HEREBY CERTIFY, That I attended deceased from April 8th., 19 1927 to Oct. 6th. 1927

that I last saw him alive on Oct. 6th. 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 5 mos 28 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1681 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct. 9, 1927
20 UNDERTAKER: Mrs. Katie R. Williams	ADDRESS 322 W. Edmondson St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26232

CERTIFICATE OF DEATH.

E 26232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 W. Mulberry St. ST., 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Ann Minness

(a) RESIDENCE NO. 1621 W. Mulberry St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of JOHN Minness

6 DATE OF BIRTH (month, day, and year) Aug. 4th. 1869

7 AGE: Years 58 | Months 3 | Days 2 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Herself

9 BIRTHPLACE (city or town) (State or country) Accomac Va.

PARENTS

10 NAME OF FATHER Louis Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Va.

12 MAIDEN NAME OF MOTHER Jane Watson

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Accomac Co. Va.

14 Informant May Lancaster (Doughter)

(Address) 1631 W. Mulberry St.

15 Filed , 19 RKK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6-1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28th. 1927 to Oct. 6th. 27.

that I last saw her alive on Oct. 5th. 1927

and that death occurred, on the date stated above, at 3.15 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 17 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1621 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Oct. 19

20 UNDERTAKER J. L. Brown & Son

ADDRESS 107 [illegible]

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26233 E 26233

CERTIFICATE OF DEATH.

REGISTERED NO. 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2361 (St.) McCulloh (Ward) 13-24

2-FULL NAME Garrison Mitchell

(a) RESIDENCE NO. 2361 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Race Horses

(c) Name of employer Mc Daniels Stable

9 BIRTHPLACE (city or town) (State or country) Lexington Ky.

PARENTS

10 NAME OF FATHER George Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Catherine Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

14 Informant John Mitchell (Address) 2361 McCulloh St

15 Filed ..., 19... Registrar ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1927, to Oct 5 1927, that I last saw him alive on Oct 5, 1927 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. 1 mos. 30 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Symptoms

(Signed) Thos Woolard M. D.

(Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Oct 7 1927

20 UNDERTAKER Samuel Hensley ADDRESS 1128 W Baltimore

RRR

Spec.—1-10-21—M&T—1500 Blks.

E 26234 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26234

CERTIFICATE OF DEATH.

REGISTERED NO. 101

1-PLACE OF DEATH Bells

CITY OF BALTIMORE: (No.) 731 Franklin ST. (WARD) 4-16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gabriel Graham

(a) RESIDENCE NO. 731 W Franklin ST., WARD 17

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write this word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Corine Graham

6 DATE OF BIRTH (month, day, and year) Sept 24th 1885

7 AGE Years 42 Months 8 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Cummings Sugar Refy

9 BIRTHPLACE (city or town) (State or country) Thus Island

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Thus Island

12 MAIDEN NAME OF MOTHER Louise Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Corine Graham (Address) 731 W Franklin

15 Filed , 19 CRK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 24th, 1927, to Oct 5th, 1927, that I last saw h alive on Oct 1st, 1927, and that death occurred, on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows: Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Maxwell Hyde, M. D.

, 19 (Address) 111 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thus Island S.C. DATE OF BURIAL Oct 7 19 27

20 UNDERTAKER Samuel Stanley ADDRESS Baltimore

This is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Edward T Kirby

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 26235

CERTIFICATE OF DEATH.

129

REGISTERED NO.

E 26235

1-PLACE OF DEATH

City of BALTIMORE: (No. 2024 W Saratoga St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward T. Riley (Kirby)

(a) RESIDENCE NO. 2024 W Saratoga St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fanny Kirby

6 DATE OF BIRTH (month, day, and year): 8 29 1867

7 AGE: Years 60 | Months 2 | Days 19 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Parker

(b) General nature of industry, business, or establishment in which employed (or employer): 1

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Cecil Co Md

PARENTS

10 NAME OF FATHER: Thos C Kirby

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Mary Dugan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Harford Co Md

14 Informant: Wilton E. Kirby

(Address): Son 734 E Preston

15 Filed 19 Nov 1 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 10-6-27

17

I HEREBY CERTIFY, That I attended deceased from Oct 1st 19 27 to Oct 6 19 27, that I last saw h.. alive on Oct 5 19 27, and that death occurred, on the date stated above, at 4 40 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj. C. McCreary, M. D.

10/6. 1927 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudenslager Md Date of Burial Oct 8 1927

20 UNDERTAKER: Robt J Turner ADDRESS 1012 W. Baltimore

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26236 ✓ 123 E 26236

E 26236

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital ST. 23 W WARD)

2-FULL NAME Mary Calwa (Mary Kalwa)

(a) RESIDENCE NO. 411 S. Bond Street ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Vincent Calwa

6 DATE OF BIRTH (month, day, and year): 1886 Sept 8

7 AGE — Years: 41 — Months: 1 — Days: 28 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records.

15 Filed ....., 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-6-27 19

17 I HEREBY CERTIFY, That I attended deceased from 9-29-27, 19, to 10-6-27, 19, that I last saw h[illegible] alive on 10-6-27, 19, and that death occurred, on the date stated above, at 3 45 a m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(duration) 0 yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary): Pulmonary Embolism

(duration) yrs. 30 minutes mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9 31 27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Cecil M. Hall, M. D.

10/6, 1927 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: 10/10 1927

20 UNDERTAKER: Williams Galloway — ADDRESS: 1618 Eastern

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117

1. PLACE OF DEATH — REGISTERED NO. B 26237

City of BALTIMORE: (No. Md. Gen. Hosp. St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Younghenn

(a) RESIDENCE NO. 1172 Hanlicoke St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S. if of foreign birth life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augusta Younghenn

6 DATE OF BIRTH (month, day and year): Mar. 21, 1854

7 AGE — Years: 73 — Months: 6 — Days: 15 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): 067

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Wm. Younghenn

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Carolina Eckart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs Augusta Younghenn

(Address) 1172 Hanlicoke St

15 Filed ..... (. 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10—6 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-29, 1927, to 10-6, 1927, that I last saw him alive on 10-6, 1927, and that death occurred, on the date stated above, at 3 30 A.m.

The CAUSE OF DEATH* was as follows:

Peritonitis due to ruptured appendix

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumonia edema due to myocarditis arteriosclerosis

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 9-29-27

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical signs

(Signed) Jno. Younghenn M. D.

. 19 (Address) 1172 Hanlicoke St

*State the Disease Causing Death, or in Deaths from Violence, State (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: 10/8 1927

20 UNDERTAKER: Albert L Hilty — ADDRESS: 1605 N Chester

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 35 E 26238

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 74 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel E. Duncan.

(a) RESIDENCE NO. Waldron - Arkansas ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~: Jr Aggie Duncan

6 DATE OF BIRTH (month, day, and year): 4-7-70

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Arkansas

PARENTS

10 NAME OF FATHER: S. E. Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Arkansas

12 MAIDEN NAME OF MOTHER: Isabel Liggett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Illinois

14 Informant: Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug-25, 1927, to Oct-6, 1927, that I last saw h alive on October 6, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH was as follows:

Benign Prostatic Hypertrophy

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial failure,

(duration) yrs. 1 mos. 24 ds.

18 Where was disease contracted if not at place of death? Waldron, Ark,

Did an operation precede death? Yes. Date of About Sept. 1.

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) E. E. James, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fort Smith Ark — DATE OF BURIAL: 10/7/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26239

CERTIFICATE OF DEATH.

90 E 26239
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) West Baltimore Gen Hosp ST., (WARD)

2-FULL NAME Mrs Bertha McDonald

(a) RESIDENCE NO. 3124 Montebello Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles R McDonald

6 DATE OF BIRTH (month, day, and year) May 10 1873

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
54	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Paul Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Charles R McDonald (Address) 3124 Montebello Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 1, 1927, that I last saw h[illegible] alive on Oct 1, 1927 and that death occurred, on the date stated above, at 1 30 Am.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) 2 yrs. 6 mos [illegible] ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Mons D. Cahn M. D.

19 (Address) West Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Oct 10 1927

UNDERTAKER William Cook ADDRESS 502 E Baltimore

Spec.—1-12-23—M&T—500 Bks.

E 635 — 36240

HEALTH DEPARTMENT—CITY OF BALTIMORE — 26240

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME T. Ernest Vest

(a) RESIDENCE NO. Myrtle Av. ST., Essex-Md WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, ~~(write the word)~~: Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26/27

7 AGE: Years — Months 3 — Days 9 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest Vest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Viola Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hosp. JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1927, to Oct. 5, 1927, that I last saw h alive on Oct. 5, 1927, and that death occurred, on the date stated above, at 930 P m.

The CAUSE OF DEATH* was as follows:

Entero colitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Myrtle Essex Md

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Oct. 8 1927

20 UNDERTAKER John G. Connelly ADDRESS Essex Md.

Spec.—1-12-23—M&T—500 Bks.

E 26241

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26241

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. .... EW ST., 19 WARD)

2-FULL NAME William McEwan

(a) RESIDENCE NO. Endowment ST. .... WARD ....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred .... yrs. .... mos. 7 ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret McEwan

6 DATE OF BIRTH (month, day, and year) 7-20-63

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
64	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Landscape Gardener

(b) General nature of industry, business, or establishment in which employed (or employer) 026

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER William McEwan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Lewellin ?

13 BIRTHPLACE OF MOTHER (city or town) .... (State or country) Scotland

14 Informant JOHNS HOPKINS HOSPITAL

(Address) Woods

15 Filed .... 19 .... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1927, to Oct 4, 1927, that I last saw h alive on Oct 4, 1927, and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows: (Post operative)

Paralytic Ileus – 24 hrs.
Miliary tbc – duration ?

(duration) .... yrs. .... mos .... ds.

CONTRIBUTORY (Secondary) Pulmonary tbc.

(duration) 3 yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10/3/27

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) Norma Myers, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Oct 8 1927

20 UNDERTAKER John H. Denny — ADDRESS 715 Lights

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26242

CERTIFICATE OF DEATH.

E 26242

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 818 N. Central Ave ST., 16-14 WARD)

2-FULL NAME Mary Schilling

(a) RESIDENCE No. 818 N. Central Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ferdinand Schilling

6 DATE OF BIRTH (month, day, and year): May 23, 1849

7 AGE — Years: 78 — Months: 4 — Days: 13 — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md. Harford

PARENTS

10 NAME OF FATHER: Bernard Schilling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary A. Kerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Thomas Deaver

(Address) 2278 Edmondson Boulevard

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1927, to Oct. 5, 1927, that I last saw her alive on Oct. 5, 1927, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Entero-Colitis

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar V. Sandrock, M. D.

. 19 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct 9 1927

20 UNDERTAKER: Jonah Deford & Sons — ADDRESS: W. North Ave

FROM is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 26243

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26243

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Guyon Falls Drive ST. 5-66 WARD)

2-FULL NAME Philip Robinson

(a) RESIDENCE. NO. Guyon Falls Drive ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Philip Robinson Jr.
(Address) 816 Whitehall

15 Filed ..... 19 .....
C. CHAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1927

17

I HEREBY CERTIFY, That I attended deceased from July — 1926 to Oct 5 1927, that I last saw him alive on Oct 4 1927, and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) A. C. Smith, M. D.

Oct. 1927 (Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	Oct 8 1927

20 UNDERTAKER Wm. J. Chase Son ADDRESS Fox meadow

Spec.—1-10-21—M&T—1500 Bks.

E 26244

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26244

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 N Carrollton Ave. ST.; WARD)

REGISTERED NO. 1-2390

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas George

(a) RESIDENCE NO. 1212 N Carrollton Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ella George

6 DATE OF BIRTH (month, day, and year): Dec 7 1881

7 AGE: Years 45 46. Months 9 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer): ob

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Wm George

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Antman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Mrs Ella George 1212 Carrollton Ave

15 Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 4th. 1927. to Oct 6th. 1927.

that I last saw him alive on Oct 6th. 1927

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Chr. Myocarditis

(duration) two yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harris Goldman, M. D.

10/6, 1927 (Address) 1816 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Oct 9th 27

20 UNDERTAKER: Samuel E Warfield

ADDRESS: 1364 W Mary

TION is very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26245

CERTIFICATE OF DEATH

46 E 26245

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 210 Poplar ave St., 27-42 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence S Bullinger

(a) RESIDENCE NO. 210 Poplar Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas D Bullinger

6 DATE OF BIRTH (month, day, and year): May 14 1852

7 AGE: Years 75 Months 4 Days 14

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: Daniel Bergan

11 BIRTHPLACE OF FATHER (City or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER: Eliz Brandon

13 BIRTHPLACE OF MOTHER (City or town) Baltimore Md

(State or country)

14 Informant: Mary Bullinger

(Address) 210 Poplar Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 17, 1926, to Oct 6 1927,

that I last saw h— alive on Oct 6 1927

and that death occurred, on the date stated above, at 3 40 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Edward Bentch, M. D.

10/7/1927 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Date of Burial Oct 8 1927

20 UNDERTAKER: Williamson & Natta ADDRESS

C. HAMPSON JONES, M. D.

1927 Phy

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

E 26246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 26246

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Curtis

(a) RESIDENCE NO. State Normal school St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 47 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night

(b) General nature of industry, business, or establishment in which employed (or employer): Watchman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Princess Anne Md

PARENTS

10 NAME OF FATHER: John Curtis

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Caroline Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Viola Curtis

(Address) Bowie Md

15 Filed ..., 19 ... Registrar

RFG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Oct 6-27

17 I HEREBY CERTIFY, That I attended deceased from Oct 2-27, 19 ... to Oct 6-27, 19 ..., that I last saw h... alive on Oct 6-27, 19 ..., and that death occurred, on the date stated above, at 9 30 P.M. The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? ... Date of ...

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Emil Solomon, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Princess Anne Md Date of Burial Oct 8 19 27

20 UNDERTAKER: Samuel Hensley ADDRESS W Baltimore

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26247

CERTIFICATE OF DEATH.

12 E 26247

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 561 Laurens ST., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Johnson

(a) RESIDENCE NO. 561 Laurens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 6th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	45	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Private Work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Randolph Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosa Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Cora Johnson

(Address) 914 N. Eutaw St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Octr 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Oct 6th, 1927.

that I last saw her alive on Oct 2d, 1927,

and that death occurred, on the date stated above, at 9, [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) — yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Examination

(Signed) Edward Ellackenger M. D.

(Address) 1339 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 10/8/27

20 UNDERTAKER Samuel T Hemsley

ADDRESS 578 N Eutaw St

FROM BACK OF CERTIFICATE. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26248

CERTIFICATE OF DEATH.

170 E 26248

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. U. S. Marine Hospital St. 21-53 Ward)

2-FULL NAME John Hanson

(a) RESIDENCE NO. 117 Goodwood Road St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ida Hanson

6 DATE OF BIRTH (month, day, and year)
October 11, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	11	24	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Captain

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Ida Hanson,
(Address) 117 Goodwood Road, Hamilton

15 Filed....., 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:
Paralysis of Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBITORY
(Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) (Coroner) M. D.

(Address) 7632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — Date of Burial: Oct. 8, 1927

20 UNDERTAKER: E. Leroy Stiffler — ADDRESS: 125 E. North

E. Leroy Stiffler

Spec.—1-12-23—M&T—500 Bks.

E 26249

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26249

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Coulter

(a) RESIDENCE NO. 1 Edgewood Rd ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-8-27

7 AGE — Years | Months 3 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Morris Coulter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Greenfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1927, to Oct 7, 1927, that I last saw h.e alive on Oct 7, 1927, and that death occurred, on the date stated above, at 11:24 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery - bacillary

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood and Smear + Stools

(Signed) Allan Blackman, M. D.

, 19 (Address) The Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Christian Cem. — DATE OF BURIAL: Oct 8 1927

20 UNDERTAKER: Horneffer & Sons — ADDRESS: Benson, Md.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26250

CERTIFICATE OF DEATH

101-001 E 26250

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 645 W. Barre St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Jones

(a) RESIDENCE NO. 645 W Barre St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 4 mos. — ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June - 1889

7 AGE: Years 38 Months 4 Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 62

(c) Name of employer Consolidated Gas & Elec

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Jones

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Queenie West

(Address) 645 W Barre St

15 Filed ....., 19 .....

Registrar RFH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sep - 30, 1927, to Oct - 6, 1927, that I last saw h[illegible] alive on Oct 5, 1927, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dan'l Chandler M. D.

10/6. 1927 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial Oct 8 1927

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Eutaw St

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26251 ✓ E 26251

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Lombard & Greene Sts St. 4-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Harcum

(a) RESIDENCE NO. Preston Maryland St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Sadie Harcum

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: 39 (about) Months: Days: IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown 027

(b) General nature of indostry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Unknown

(State or country)

PARENTS

10 NAME OF FATHER Elijah Harcum

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Julia

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10-6-27

17 I HEREBY CERTIFY, That I attended deceased from 9-19, 1927 to 10-6, 1927

that I last saw h~~im~~ alive on 10-6, 1927

and that death occurred, on the date stated above, at 3:15 a m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cellulitis of lower extremity (duration) 2 weeks

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) John Roberts Phillips, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hurlock, Md — Date of Burial: Oct 8 1927

20 UNDERTAKER: Wm J Tucker & Sons — ADDRESS: Fort Ave

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26252

CERTIFICATE OF DEATH

129 E 26252

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1517 W. Fayette St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Jane Walker

(a) RESIDENCE NO. 1517 W. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William G. Walker

6 DATE OF BIRTH (month, day, and year): Oct 15th 1856

7 AGE: Years 46 Months 11 Days 22 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 1037

(c) Name of employer: Howard Co., 2026

9 BIRTHPLACE (city or town): Howard Co.,

(State or country)

PARENTS

10 NAME OF FATHER: Alfred Duncan

11 BIRTHPLACE OF FATHER (City or town): Howard Co.

(State or country)

12 MAIDEN NAME OF MOTHER: Louisa Nelson

13 BIRTHPLACE OF MOTHER (City or town): Howard Co.

(State or country)

14 Informant: Mrs. Louise Williams

(Address) 1517 W. Fayette St.

15 Filed . 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 26th, 1927, to Oct 7th, 1927, that I last saw h.. alive on Oct 7th, 1927, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Edwards, M. D.

, 19 (Address) 913 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westen star — Date of Burial 10-11 1927

20 UNDERTAKER: Joseph A Lively — ADDRESS 409 N Mount

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 26253

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Sterling ST. 10-14 WARD)

2-FULL NAME Samuel Sparks,

(a) RESIDENCE NO. 704 Sterling ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Sparks

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steveder

(b) General nature of industry, business, or establishment in which employed (or employer) C/T

(c) Name of employer Vaivur

9 BIRTHPLACE (city or town) (State or country) Kent Co, Md

PARENTS

10 NAME OF FATHER — Sparks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Sparks
(Address) 704 Sterling St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1927

17

I HEREBY CERTIFY, That I attended deceased from ~~Sept~~ 26, 1927, to Oct 6, 1927, that I last saw ~~her~~ alive on Oct 6, 1927 and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ~~Date of~~

Was there an autopsy? ~~no~~

What test confirmed diagnosis?

(Signed) Dudley L Pentalcoste M. D.

1927 (Address) 1638 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery — DATE OF BURIAL Oct 10 1927

20 UNDERTAKER Edward Bryon — ADDRESS 1631 Orleans St

Spec.—1-12-23—M&T—500 Bks.

E 26254

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 26254

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. B 418 N. Durham ST. 6-9 WARD)

2-FULL NAME James Williams

(a) RESIDENCE No. 418 N. Durham ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Williams

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) V. a.

PARENTS

10 NAME OF FATHER Henry Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) V. a

12 MAIDEN NAME OF MOTHER Priscilla Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) V. a

14 Informant Mary J. Searcy

(Address) 418 N. Durham st

15 Filed ... , 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept 28, 19 27, to Oct 5 19 27

that I last saw him alive on Sept 5 19 27

and that death occurred, on the date stated above, at 3 P m

The CAUSE OF DEATH* was as follows:

Cardio Renal

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Webb Clinton, M. D.

19 27 (Address) 508 Somerset

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Arbury cemetery

DATE OF BURIAL Oct 9 1927

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

Spec.–7-17-26—A Co.—200 Bks.

E 26255

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 26255

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1007 N. Central Ave St. 1654 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin. T. Hentze

(a) RESIDENCE NO. 1007 N. Central Ave St. 10 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 11 mos. 16 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mr. Sophia K. Hentze

6 DATE OF BIRTH (month, day, and year): October 21st 1870

7 AGE: Years 56 Months 11 Days 16 IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery & Provision

(b) General nature of industry, business, or establishment in which employed (or employer): Business

(c) Name of employer

9 BIRTHPLACE (city or town): Balto (State or country) Md

PARENTS

10 NAME OF FATHER: Vitus Hentze

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. Sophia K. Hentze (Address) 1007 N. Central Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 7th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 2d, 19 27, to Oct 7th, 19 27, that I last saw her alive on Oct 7th, 19 27, and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) ... yrs. 10 mos ... ds.

CONTRIBUTORY (Secondary) Cancer

(duration) ... yrs. ... mos ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Selmer, M. D.

Oct 7, 19 27 (Address) 501 S. Eaton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Oct. 10 1927

20 UNDERTAKER: J. Henry Hoeck & Son — ADDRESS: 1301 E. Eager St

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26256

CERTIFICATE OF DEATH

96 E 26256

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1315 Ensor St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moritz Nickol

(a) RESIDENCE NO. 1315 Ensor St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. — mos. — ds. How long in U. S. if of foreign birth 85 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Anna M. Nickol

6 DATE OF BIRTH (month, day, and year) October 8 1845

7 AGE	Years	Months	Days	IF LESS than I day ____ hrs. or ____ min..
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Bkl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER John Nickol

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Steinmuel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Andrew E. Nickol

(Address) 1315 Ensor St

15 Filed ____, 19 ____ NRA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21st, 1927, to Oct 8th, 1927, that I last saw him alive on Oct 7th, 1927, and that death occurred, on the date stated above, at 5-45 A. M.

The CAUSE OF DEATH* was as follows:

Intra Lung Tumor

Arteriosclerosis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Leonard M. C. Corbin, M. D.

1914 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Oct. 11 1927

20 UNDERTAKER: Henry Hoeck & Son — ADDRESS: 1301 E. Eager St

very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26257 E 26257

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 27 Rosemont Ave ST. 27-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Bahlke

(Residence in Baltimore: No. 27 Rosemont Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Nov (Month) 10 (Day) 1850 (Year)

7-AGE, 76 yrs. 10 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... George W. Bahlke

(Address)..... 720 Fairmount Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1915, to Oct 5 1917, that I saw h[illegible] alive on October 6 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct 8, 1917 (Address) 2076 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Oct 8 1917
20-UNDERTAKER	ADDRESS
Geo Leimach & Son	239 Lexington

Spec.-7-17-26—A Co.—200 Blks.

E 26258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

164 E 26258

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Norwood Ave Sickling Sanatorium St., Ward 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen M. Paynter

(a) RESIDENCE NO. 2043 E. Hoffman St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life time (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): February 19-1852

7 AGE: Years 75 Months 7 Days 18 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Nathaniel Paynter

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Delaware

12 MAIDEN NAME OF MOTHER: Eliza Davideon

13 BIRTHPLACE OF MOTHER, (city or town):

(State or country): Florida

14 Informant: Eugene F. Paynter

(Address): 2043 E. Hoffman St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1927, to Oct. 6, 1927

that I last saw h[illegible] alive on Oct. 6, 1927

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Uremic Stenosis

(Duration) 3 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Cardiac)

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted? ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. A. Sherman, M. D.

, 19 (Address) 907 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: 10/10/27

20 UNDERTAKER: Chas. F. Grace & Son — ADDRESS: 118 W. Mt. Royal Ave

very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

E 26259

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26259

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2614 N.Charles Street ST., 12 WARD 12-51

2-FULL NAME George Dixon Clagett

(a) RESIDENCE NO. 2614 N.Charles Street ST., 12 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 51 yrs. 7 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M.Estelle Clagett

6 DATE OF BIRTH (month, day, and year) March-1-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	7	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work General Manager
(b) General nature of industry, business, or establishment in which employed (or employer) American Oil Co.
(c) Name of employer American Oil Co.

9 BIRTHPLACE (city or town) Unknown
(State or country) Montana

PARENTS

10 NAME OF FATHER William Clagett

11 BIRTHPLACE OF FATHER (city or town) Probably in
(State or country) Montana

12 MAIDEN NAME OF MOTHER Mary Hart

13 BIRTHPLACE OF MOTHER (city or town) Somewhere in
(State or country) Eastern United States.

14 Informant Mrs.M.Estelle Clagett (wife)
(Address) 2614 N.Charles Street.

15 Filed , 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Jabular Thrombosis
Of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

10/7, 192 (Address) 3632 Rutland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct-10-27 192

20 UNDERTAKER STEWART & [illegible] COMPANY ADDRESS [illegible] CATHEDRAL ST.
(Licensed Undertaker)

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26260

CERTIFICATE OF DEATH

44 E 26260

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 11-15 Ward 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Pendleton Reilly

(a) RESIDENCE NO. 213 East Preston St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A. Dunn

6 DATE OF BIRTH (month, day, and year): Nov. 10, 1873

7 AGE — Years: 53 — Months: 10 — Days: 28 — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER: David M. Reilly

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Watts

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Mrs. E. C. R. Humphreys

(Address)

15 Filed , 19 R.L.K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 10-8-'27

17 I HEREBY CERTIFY, That I attended deceased from 8-15-'27 19 , to 10-8-'27 19 .

that I last saw h. alive on 10-8-'27 . 19 .

and that death occurred, on the date stated above, at 7 5 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gall Bladder
Metastasis to adjacent structures

(duration) yrs. 4-6 mos. ds.

CONTRIBUTORY (Secondary): Carcinoma -

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 9.27.27

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Ewen Johnston M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon, Ohio

Date of Burial 19 Oct 10

20 UNDERTAKER: John C. Mitchell & Son

ADDRESS: 1700 Eutaw St

1927 CHAMPION JONES, M. D.

Per

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26261

CERTIFICATE OF DEATH

100-101 E 26261

1-PLACE OF DEATH

REGISTERED NO. 26-37

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Umbelin

(a) RESIDENCE NO. 3010 12th St N.E., Washington D.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 42 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Umbelin

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Ann ?

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/7/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1927 to Oct. 7, 1927

that I last saw him alive on Oct. 7, 1927

and that death occurred, on the date stated above, at 11 A.M. p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage, acute

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Subdural hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Unusual symptoms

(Signed) C. Stulmo Boyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington, D.C. Date of Burial 10/8/ 1927

20 UNDERTAKER L. Ryan & Co ADDRESS 327 Penn Ave N.W.

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26262

CERTIFICATE OF DEATH.

7-900-001 E 26262

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD 9)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Powell.

(a) RESIDENCE No. Walkill N York. ST., ... WARD Wall Kill New York

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Wm H Powell

11 BIRTHPLACE OF FATHER (city or town) N York (State or country) ?

12 MAIDEN NAME OF MOTHER Rebecka Powell

13 BIRTHPLACE OF MOTHER (city or town) Walden N York (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..., 19 R/C/L Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 29 - , 1927, to Oct 6 - , 1927, that I last saw him alive on Oct 5 - , 1927, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy with uremia

One year (duration) ... yrs. — mos — ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 6

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry

(Signed) William M. Mullar, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Walden N. Y. DATE OF BURIAL Oct. 9 1927

20 UNDERTAKER Wm E. Black ADDRESS 927 N. Broadway

Cor.—12-9-25—A Co.—200 Bks.

E 26263

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 E 26263

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Shade Kenneth McGee

(a) RESIDENCE NO. 1021 Ashland Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Md

PARENTS

10 NAME OF FATHER Claude McGee

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Helen Travers

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md.

14 Informant Helen McGee

(Address) 1021 Ashland Ave

15 Filed....., 19 .....

Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Primary Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. D. H. Allen M. D.

(Coroner)

10-9-27, 19 (Address) 503 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Laurel Cem 10/9 192

20 UNDERTAKER ADDRESS

Mrs Joseph U. Locke 1302 Jefferson

Spec.—1-12-23—M&T—500 Bl.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26264

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

89 E 26264

CITY OF BALTIMORE: (No. 1100 W. Lafayette av ST., 16-23 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanch M. Gubert

(a) RESIDENCE No. 1100 W. Lafayette av ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Chas H Gubert

6 DATE OF BIRTH (month, day, and year) Feby 27-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	59	7	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Lighter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Mathison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Dr Howard M. Gubert
(Address) 1100 W Lafayette av

15 Filed , 19 per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from October 6, 19 27, to October 7, 19 27, that I last saw h[illegible] alive on October 7, 19 27, and that death occurred, on the date stated above, at 4.25 a m

The CAUSE OF DEATH* was as follows:

Lingual Tetanus

CONTRIBUTORY (Secondary) (duration) Coronary Thrombosis yrs. 12 mos. 2 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Harry W. Ehlen M. D.

10/7. 19 27 (Address) 1215 N Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 19

20 UNDERTAKER Harry W. Ehlen
ADDRESS 1914 W. Northern

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26265

CERTIFICATE OF DEATH.

129

E 26265

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1913 W. Northern ST., 15-21 WARD)

2-FULL NAME Emma Rosalind Herring

(a) RESIDENCE NO. 1913 W. Northern ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of David Herring

6 DATE OF BIRTH (month, day, and year) Jany. 21-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	68	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Robert Christopher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Waldie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Clara R. Hayley

(Address) 1773 Lanvale Place

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1927, to Oct. 8, 1927, that I last saw h[illegible] alive on Oct. 7, 1927, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic interstitial

Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) R. C. [illegible] M. D.

Oct. 10 1927 (Address) 1403 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL Oct 12 1927

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1[illegible] W. North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26266

CERTIFICATE OF DEATH.

91-002

25-73

REGISTERED NO. E 26266

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Belvedere Ave ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Frank

(a) RESIDENCE No. Belvedere Ave-Lakeland. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catharine Frank

6 DATE OF BIRTH (month, day, and year): Jan 31st 1858

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): United Railways

(c) Name of employer: & Electric Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Christian Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna M. Agnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William W. Frank

(Address): Belvedere Ave. & Lakeland

15 Filed ..., 19 ... Registrar

PHL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Oct 7, 1927, that I last saw him alive on Oct 6, 1927, and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis: Physical

(Signed) H. Bruton, M. D.

10/8, 1927 (Address) 307 East Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem DATE OF BURIAL: Oct 10 1927

20 UNDERTAKER: Schlosman & Son ADDRESS 1034 Hanover

ATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 ms.

E 26267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hosp. ST., (WARD) 26-2

REGISTERED No. E 26267

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Peterka

(a) RESIDENCE No. 1525 S. Baldwin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6 27

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Carl Peterka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Peterka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) 1525 S. Baldwin St.

15 Filed . 19 . per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6 , 19 27, to Oct. 8 , 19 27.

that I last saw him alive on Oct. 8 19 27

and that death occurred, on the date stated above, at 9-30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Disease of the Newborn.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Margaret B. Ballard, M. D.

. 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loor Lutheran Cemetery — DATE OF BURIAL: Oct 9 1927

20 UNDERTAKER: Fredk Passano Sons — ADDRESS: Fulton

THIS IS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

207 E 26268 113 E 26268

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 5-8

CITY OF BALTIMORE: (No. ..... St., ... Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Hawkins

(a) RESIDENCE NO. 622 N. Eden St ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single, Married, Widowed,~~ or Divorced. (write the word): Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-28-27

7 AGE: Years: 4 months | Months: 4 | Days: 9 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph THOMAS

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER May Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mel-

14 Informant Parents JOHNS HOPKINS HOSPITAL
(Address)

15 Filed ..... 19 .... Per R.L.H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5 1927, to Oct. 7 1927, that I last saw her alive on Oct 6th 1927, and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Acute diarrhoea + enteritis

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Allen Blouson, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arbury Cemetery — DATE OF BURIAL: Oct. 8 1927

20 UNDERTAKER: Chas. M. Johnson — ADDRESS: 710 N. Caroline St.

Spec.—1-12-23—M&T—500 Bks.

E 26269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 26269

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 Greenmount Ave ST. 10-15 WARD)

2-FULL NAME Anna B. Dienstbach

(a) RESIDENCE No. 734 Greenmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND (of) or WIFE (of) Phillip Dienstbach

6 DATE OF BIRTH (month, day, and year) Dec 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Leonhardt Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frederika Fritch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma B. Dienstbach

(Address) 734 Greenmount Ave

15 Filed ..... 19 ..... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1927, to October 8, 1927, that I last saw her alive on October 8, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis
Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Emphysema & Bronchitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy. Exam

(Signed) Louis F. Klemmer, M. D.

. 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Oct 11 1927

20 UNDERTAKER J. F. Cook

ADDRESS 502 N. Gay St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 26270 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 26270

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2901 Rockrose ave ST.: 15-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Blankman

(a) RESIDENCE. No. 2901 Rockrose ave. ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hyman Blankman

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Shandler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hyman Blankman
(Address) 2901 Rockrose ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8. 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 3. 1927, to Oct. 8. 1927, that I last saw her alive on Oct. 8. 1927, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Mitral and Aortic Regurgitation

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Collingdale ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. C. Rastall M.D.

10/9. 1927 (Address) 116 Augusta ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — DATE OF BURIAL 10/9 1927

20 UNDERTAKER Jack Louis — ADDRESS 1439 E Baltimore St

Rec'd

Spec.—1-12-23—M&T—500 Blks.

E 26271

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26271

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 N. Calvert ST. 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William O. Stubbs

(a) RESIDENCE No. 1711 N. Calvert ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 30, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William O. Stubbs

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Vansant

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs Nellie R. Gregory.
(Address) 1711 N. Calvert St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 30th, 1926, to Oct 7th, 1927, that I last saw h[illegible] alive on Oct 7th, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis.

(Duration) yrs. 10 mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard E. Wood Jr. M. D.

, 19 (Address) 530 E North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Oct. 10, 1927

20 UNDERTAKER E. Leroy Stiffler

ADDRESS 125 E. North Ave.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 26272

CERTIFICATE OF DEATH

E 26272

129

REGISTERED NO. 19-26

1-PLACE OF DEATH Md. Gen. Hospital

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary E. Kirk

(a) RESIDENCE NO. 2037 N. Calhoun St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Maried

5a If married, widowed, or divorced (or) WIFE of: William R. Kirk

6 DATE OF BIRTH (month, day, and year): April 21, 1871

7 AGE — Years: 56 Months: 5 Days: 16 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife,

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Ellsworth, Conn.

(State or country)

PARENTS

10 NAME OF FATHER: Nathenial Palmer

11 BIRTHPLACE OF FATHER (City or town): Cathgow N. Y.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Lickiden

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Conn.

14 Informant (Address): Mrs. E. R. Wright 2301 N. Calhoun St

15 Filed ..... 19 ..... Registrar

OCT 5 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: October 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1927, to Oct 7, 1927, that I last saw her alive on October 7, 1927 and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcic Hemolytic Septicemia

Chronic Diffuse Nephritis

Unknown (duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos 9 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo A. Dempsey M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial Oct 10, 19 27

20 UNDERTAKER: John T. Mitchell Sons

ADDRESS

Property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26273

CERTIFICATE OF DEATH.

31 E 26273

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1072 W. Mosher St., 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Heinrich Deidersen

(a) RESIDENCE NO. 1072 W. Mosher Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Married

6a If married, widowed or divorced HUSBAND of (or) WIFE of Heinrich Diedersen

6 DATE OF BIRTH (month, day, and year) March 18, 1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 13

(c) Name of employer Penna. R. R. 67

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Henry Diedersen

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Mrs. H. Diedersen

(Address) 1072 W. Mosher St.

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

....., 19 (Address) 2572 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montgomery Co. Md. Date of Burial Mt. Hope Cem 19

20 UNDERTAKER Samuel F. Hamilton ADDRESS 578 Biddle

OCT 9 1927

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26274

E 26274

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2354 McCulloh St. 13 Ward) 90

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Holmes

(a) RESIDENCE NO. 2354 McCulloh St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Holmes

6 DATE OF BIRTH (month, day, and year) Oct 28/1867.

7 AGE	Years	Months	Days	If less than 1 day ... hrs. or ... min.
	59	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Government

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Alice Holmes

(Address) 2354 McCulloh

15 Filed ..... 19 ..... Registrar

For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D. (Coroner)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — Date of Burial OCT - 9 1927

20 UNDERTAKER Samuel F. Bowers — ADDRESS 515 N. Eutaw

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26275

CERTIFICATE OF DEATH.

118-001 E 26275

1-PLACE OF DEATH South Balto. Gen. Hosp. REGISTERED NO.

City of BALTIMORE: (No. 1211-13 Linwood St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. William Abey

(a) RESIDENCE NO. 1108 William st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 25-1848

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	84	7	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Worker (metal)
(c) Name of employer G. H. Keath

9 BIRTHPLACE (city or town) Wales
(State or country) Md.

PARENTS

10 NAME OF FATHER William Abbey.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Galloway

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Albert Abbey
(Address) 207 Hanover Ave

15 Filed....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 10-7-27

17 I HEREBY CERTIFY, That I attended deceased from 9-24, 1927, to 10-7, 1927, that I last saw h.. alive on 10-7, 1927, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:
Pulmonary edema - myocardial failure -

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hemiplegia 9-28-27.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-28-27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Flexner, M. D.

19 (Address) So Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem. Date of Burial Oct 10, 1927

20 UNDERTAKER A. Howard Evans ADDRESS 38 E. Fayette

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26276 PLACE OF DEATH

90 E 26276 REGISTERED NO.

City of BALTIMORE: (No. 1130 Argyle Ave St., 17 Ward) 24

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Julia E. Jones

(a) RESIDENCE NO. 1130 Argyle Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Private Hosp.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Atkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Daisy Fitzgerald (Sister)

(Address) 1113 Dolphin Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Oct 7, 1927, that I last saw h[illegible] alive on Oct 6, 1927 and that death occurred, on the date stated above, at 2.5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Monoplegia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

Oct 8, 1927 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery Date of Burial Oct. 9, 1927

20 UNDERTAKER J. H. & M. Johnson ADDRESS 1234 Ettings St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26277

CERTIFICATE OF DEATH.

31

E 26277

1-PLACE OF DEATH

Belair Rd 27-41

CITY OF BALTIMORE: (No. 6 Southern Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdeline Biles

(a) RESIDENCE No. 6 Southern Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. – mos. ds. How long in U. S., if of foreign birth? 28 yrs. – mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Biles

6 DATE OF BIRTH (month, day, and year): No. 1899

7 AGE: 28 Years – Months Days. If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No.

(b) General nature of industry, business, or establishment in which employed (or employer): 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: G. Gustitis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithvania

12 MAIDEN NAME OF MOTHER: M. Lazavskas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithvania

14

Informant: M. Gustitis

(Address): 6 Southern Ave

15

Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7th 19 27

17

I HEREBY CERTIFY, That I attended deceased from May 14 , 1927 , to Oct 5th , 19 27 ,

that I last saw her alive on Oct 5th , 19 27 ,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs 2 mos ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Edwin W Benson , M. D.

10/8, 19 27 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Oct. 11, 1927

20 UNDERTAKER: John Greblinuckas

ADDRESS: 425 S. Broadway

Cor.—12-9-25—A Co.—200 Bks.

E 26278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-001

E 26278

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2587 West Baltimore St., 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Joseph Koenig

(a) RESIDENCE NO. 2587 West Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugenia B. Koenig

6 DATE OF BIRTH (month, day, and year) May 30, 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	43	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. Sausage

(b) General nature of industry, business, or establishment in which employed (or employer) Department

(c) Name of employer Swift & Co.

9 BIRTHPLACE (city or town) Rittersville

(State or country) Pa.

PARENTS

10 NAME OF FATHER M. Koenig

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Caroline ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs. Eugenia B. Koenig

(Address) 2587 W. Baltimore St.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 7th 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by me and Inquiry

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas Suicide - Dead when found

Oct 9th 1927

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Signed Hall B. Norton M. D.

(Coroner)

(Address) Cedar and Curtis Ave. Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Allentown, Pa.

Date of Burial shipment 10/10/1927

20 UNDERTAKER Geo. D. Cook

ADDRESS 1009 W. Baltimore St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26279

38 V

E 26279

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] St., 16 Ward) BALTIMORE CITY HOSPITALS

REGISTERED NO. [illegible]

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Miller

(a) RESIDENCE NO. 1001 N. Monroe St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE 62 Years Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Penn

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7 1927

17 I HEREBY CERTIFY, That I attended deceased from 3-29, 1926, to 10-7, 1927

that I last saw her alive on 10-7, 1927

and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis - Tabes Dorsalis
Multiple Charcot Joints

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) C. Holmes Boyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Pa — Date of Burial 10/10 1927

20 UNDERTAKER J. A. Moran — ADDRESS 3000 E. Baltimore

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~25628~~ 90 **E 26280**

E 26280

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1840 Belt St. St., 24-34 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Cadden.

(a) RESIDENCE NO. 1840 Belt St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ds. How long in U. S., if of foreign birth? 40 yrs. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Married

5a If married, widowed, or divorced HUSBAND of XXXXXXXXXX Mary Cadden.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant Mary Cadden. (wife)

(Address) 1840 Belt St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 7, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Signed Chas. Leonhardt M. D.
(Coroner)

10/8 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetry Date of Burial 10/10 1927

20 UNDERTAKER Morgan & Turner ADDRESS 1421 Eutaw St

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26281 ~~26279~~. 100-001 E 26281

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Colonial Hospital St., 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Friederick

(a) RESIDENCE NO. 1030 E. Fort Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Friederick

6 DATE OF BIRTH (month, day, and year) March 13th., 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	40	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer B & O. R. R.

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Eva Short
(Address) 1030 E. Fort Ave

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 19 27, to Oct 7, 19 27.

that I last saw him alive on Oct 7, 19 27.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ....yrs. ....mos. 11 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. data

(Signed) Leo Schlenger, M. D.

Oct 9, 19 27 (Address) 3834 E Balto St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetry — Date of Burial 10/10/1927

20 UNDERTAKER Margaret G Flynn — ADDRESS 1425 Eight St

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26282

E 26282

CERTIFICATE OF DEATH.

129

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 534 E 22nd St., 9-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Fisher

(a) RESIDENCE NO. 534 E 22nd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Mary Barry Fisher

6 DATE OF BIRTH (month, day, and year): Sept 29 - 1836

7 AGE: Years 91 | Months 0 | Days 8 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town) _____ (State or country) York Pa

PARENTS

10 NAME OF FATHER Robert Fisher

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Harrisburg Pa.

12 MAIDEN NAME OF MOTHER Catherine Jamesson

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Baltimore Md

14 Informant Miss Katherine Fisher

(Address) 534 E 22nd St

15 Filed _____ 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 7, 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Oct 7, 1927, that I last saw him alive on Oct 6, 1927, and that death occurred, on the date stated above, at 2.25 a m.

The CAUSE OF DEATH* was as follows: Uraemic Coma & Chr. Interstitial Nephritis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Prostatitis & Chr. Cystitis

(duration) ? yrs. mos. ds.

18 Where was disease contracted —

If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. R. Draught, M. D.

Oct 7 1927 (Address) 2225 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial 10/10/27

20 UNDERTAKER: Mary M. Wiedefeld — ADDRESS 501 E 22nd St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26283

CERTIFICATE OF DEATH.

E 26283

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Ramswood Ave ST., ... WARD)

2-FULL NAME Christina Henrietta Haas.

(a) RESIDENCE NO. 3704 Ramswood Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 10 mos. ..... ds. How long in U. S., if of foreign birth? 48 yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Zachary L. Haas.

6 DATE OF BIRTH (month, day, and year) May 31 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Reichbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Wm. A. Mullen

(Address) 3702 Ramswood Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1927, to Oct 5, 1927, that I last saw h.. alive on Oct 2, 1927, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

10 (Signed) D. M. Barnes, M. D.

9, 1927 (Address) 1512 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Park Cem	Oct 11 1927

20 UNDERTAKER Wm. J. Cook ADDRESS 1003 N. Eutaw St

PRINT very important. See instructions on back of certificate.

Spec.–7-17-26 –A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26284

CERTIFICATE OF DEATH

101-001

E 26284

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hosp, St., 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas DeVes

(a) RESIDENCE NO. 201 N. Pine St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah E. DeVes

6 DATE OF BIRTH (month, day, and year) October 26, 1844

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	82	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER John Deves

11 BIRTHPLACE OF FATHER (City or town) Hillsdale

(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Mrs. Ella Kearney

(Address) Forest Park Ave. Hillsdale

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Oct. 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from 5-28- 19 27 to Oct 7 19 27

that I last saw ~~him~~ alive on Oct 7, 19 27

and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Myocardial Insufficiency

(duration) Indefinite ds.

CONTRIBUTORY (Secondary) Colon Infection

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

10 (Signed) J. Blackwell, M. D.

18, 1927 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Date of Burial Oct. 10 19 27

20 UNDERTAKER Robt. D. Cook ADDRESS 1003 W. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH 185 E 26285

E 26285

REGISTERED NO. 20-69

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Schmidt

(a) RESIDENCE NO. 2162 Penrose Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14 1848

7 AGE: Years 78 Months 10 Days 24 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): Self 0/3

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER Thomas Schmidt

11 BIRTHPLACE OF FATHER (City or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Hosp Record (Address) Md Gen Hosp

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5-1927

17 I HEREBY CERTIFY, That I attended deceased from 9-8 1927 to 10-5 1927

that I last saw him alive on 10-5 1927

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Fracture of trochanter of left femur

(Duration) ..... yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Fat embolism

Few minutes

(Duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at shop

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical impression

(Signed) Wm Van Hoper, M. D.

(Address)

*State the Disease causing Death, or in deaths from Violent Canses, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem Date of Burial Oct 7" 1927

20 UNDERTAKER: Rudolph Cook ADDRESS 1003 N. Gilmor St

very important. See instructions on back of certificates.

Bpsc.—7-17-26—A Co.—200 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26286

E 26286

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 31

City of BALTIMORE: (No. 3200 Chestnut Avenue. ~~3K~~ 13-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eldridge J. Phebus.

(a) RESIDENCE NO. 3200 Chestnut Avenue~~xx~~ Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31/1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	26.	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work book keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co.

(State or country) Maryland.

PARENTS

10 NAME OF FATHER John F. Franklin.

11 BIRTHPLACE OF FATHER (City or town) Fredk, Co.

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER I. Alice Snyder.

13 BIRTHPLACE OF MOTHER (city or town) Fredk, Co.

(State or country) Maryland.

14 Informant I. Alice Phebus Willey (mother)

(Address) 3200 Chestnut Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7. 19 1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct 2 E, 19 27, to Oct 7, 19 27.

that I last saw him alive on Oct 7, 19 27.

and that death occurred, on the date stated above, at 8-20. P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

10/8, 1927 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn Cemetery.	Oct, 10/ 1927.
20 UNDERTAKER	ADDRESS
J. Walter Davis,	3307 Paine St.

very important. See instructions on back of certificates. Last statement of OCCUPATION is

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26287

CERTIFICATE OF DEATH. 161-001

REGISTERED NO. E 26287

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Madeira Ave ST.: 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hermann Horst (Rausch)

(Residence in Baltimore: No. 2500 Madeira Ave St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	

6-DATE OF BIRTH, Sept 8, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. ...mos. 1 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Martin Rausch

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lillian Horst

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 2500 Madeira Ave

15-

Filed ..... 191.....

Per ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 8 1917, to Oct 9 1917, that I saw him alive on Oct 9 1917, and that death occurred, on the date stated above, at 2 10 m.

The CAUSE OF DEATH* was as follows:

Rheumatic Fever (6 mos)

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) Henry Schamberger M. D.

Oct 10 1917 (Address) 2600 Madeira Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 10 1917

20-UNDERTAKER Wm Miller & Sons — ADDRESS 2512 Wilkens Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26288

CERTIFICATE OF DEATH.

90 **E 26288**

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2835 N. Calvert ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Walker Sr.

(a) RESIDENCE No. 2835 N. Calvert ST., ... WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 13 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Bitter

6 DATE OF BIRTH (month, day, and year): Jan. 24, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Grain Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Henry Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Harry Walker
(Address): 2835 N. Calvert St.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, . . 1917, to Oct 7, 1927.

that I last saw him alive on Oct 7, 1927

and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 10+ yrs. mos. ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) 20 yrs+ mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ronald I. Abercrombie M. D.

Oct 8, 1927 (Address) 18 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 10/10 1927

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 30 S. Calvert

Spec.—1-12-23—M&T—500 Bks.

E 26289

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 26289

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1803 E. Chase ST., 8-13 WARD

2-FULL NAME John W. Jones

(a) RESIDENCE NO. 1803 E. Chase ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Jones

6 DATE OF BIRTH (month, day, and year) Feb. 8-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
81	82	7	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Elias T. Jirkler

(Address) 2504 Parkview Terrace

15 Filed ..... 19 R.H.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1927, to Oct 8, 1927, that I last saw h— alive on Oct 7, 1927 and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia (duration) yrs. mos 5 ds.

Chronic Intestitial Nephritis Arteriosclerosis

CONTRIBUTORY (secondary)

Chronic Cystitis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B. Freeman, M. D.

Oct 8, 1927 Address 1801 Collington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct. 11 1927

20 UNDERTAKER: George W. Jirkler — ADDRESS: 1737 E. Eager St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26290

CERTIFICATE OF DEATH. 100-001

E 26290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 S. East Ave St., 1-1 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Valentine M. Hamer

(a) RESIDENCE No. 1002 S. East Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 7-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Conrad Hamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Lillian Stine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Elizabeth Hamer
(Address) 1019 S. East ave

15 Filed , 19 , Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1927

17 I HEREBY CERTIFY, That I attended deceased from October 5, 1927, to Oct. 8th, 1927, that I last saw h[illegible] alive on Oct 8th, 1927 and that death occurred, on the date stated above, at 6.40 A m

The CAUSE OF DEATH* was as follows:

Cardiac and respiratory failure.

CONTRIBUTORY (Secondary) (duration) Broncho-pneumonia. yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 1 ds. 1102 S. East Ave.

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? physical signs

(Signed) Harry J. Kates, M. D.

, 19 (Address) 3200 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL Oct. 11 1927

20 UNDERTAKER George N. Zirkler ADDRESS 1737 E. Eager St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26291

CERTIFICATE OF DEATH

7/1-001

E 26291
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 939 West Lombard St., 12-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie E. Matthews

(a) RESIDENCE NO. 939 West Lombard St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July, 1st. 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	XXX	3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James L. Matthews

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Hattie E. Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant James L. Matthews
(Address) 939 W. Lombard Street

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October, 8th. 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 19 27, to Oct 8, 19 27
that I last saw her alive on Oct 8, 19 27
and that death occurred, on the date stated above, at 11.10 P.M.
The CAUSE OF DEATH* was as follows:

Simple Meningitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Mc Feinberger M. D.
10/9. 19 27 (Address) 682 Washington Blvd.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Oct 11" 1927

20 UNDERTAKER Robert S Cook ADDRESS 1003 N. Balto St

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26292

CERTIFICATE OF DEATH.

188-003

E 26292

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 5-8 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Lemmon

(a) RESIDENCE NO. S. W. Cor Hugh & Elm St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 64 yrs; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Packing House

(b) General nature of industry, business, or establishment in which employed (or employer): Employee

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Ben. Lemmon

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Hamuth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant: Mrs Agnes Lemmon

(Address) 322 Eagle

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 8 (8) 1927

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to (Inquest, autopsy or inquiry.) his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Fract. of Skull and internal injuries = Lemon Lap. Struck by auto "but not mortally"

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Wilkesley (Coroner) M. D.

, 19 (Address) 1029 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz's Cemetery Date of Burial Oct 10 1927

20 UNDERTAKER: Lilly & Zeider ADDRESS 403 N. Howard St.

very important. See instructions on back of certificate.

Spec.—1-12 23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26293
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31 E 26293
REGISTERED NO.

CITY OF BALTIMORE: (No. 1901 Jefferson ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander H. Schlosberg

(a) RESIDENCE No. 1901 Hefferson ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sarah Schlosberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Boris Schlosberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Pearl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sarah Schlosberg (Wife)
(Address) 1901 Jefferson

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-10- 1927

17 I HEREBY CERTIFY, That I attended deceased from January, 1926 to Oct 10, 1927, that I last saw him alive on Oct 9, 1927, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insuff.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. exam.

(Signed) Jaur Cohen, M. D.

Oct 6, 1927 (Address) 2233 Bancroft

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lawn Rosedale — DATE OF BURIAL 10-10 1927

20 UNDERTAKER East Lewis, 1 & 31 E. f — ADDRESS

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26294

CERTIFICATE OF DEATH

129

E 26294

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1029 W Barre St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Swan

(a) RESIDENCE NO. 1029 W Barre St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Est~~ Amanda Swan

6 DATE OF BIRTH (month, day, and year): Oct 17 1851

7 AGE: Years 75 Months 11 Days 20 If LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Straw Hat maker

(b) General nature of industry, business, or establishment in which employed (or employer): 45

(c) Name of employer: Holts Fruit

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Benjamin Swan

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va Eastn

14 Informant: Fanny B. (Address) 1029 W Barre St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 9 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/28 1927, to Oct. 8 1927, that I last saw h[illegible] alive on Oct. 8 1927 and that death occurred, on the date stated above, at 1 00 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hubert Thompson M. D.

(Address) 642 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Oct 11 1927

20 UNDERTAKER: Wm Cook — ADDRESS 502 E North Ave

very important. See instructions on back of certificates. Last statement of OCCUPATION is

CHAMBERS M.D.

OCT 10 1927

Spec.—1-10-21—M&T—1500 Bks.

Prasecki

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26295

CERTIFICATE OF DEATH.

161-001

E 26295

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 S. Lakewood ave) (WARD) 1-3

2-FULL NAME William E. Prasecki

(a) RESIDENCE No. 728 S. Lakewood ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 9 1927

7 AGE — Years — Months — Days — If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER Walter Prasecki

11 BIRTHPLACE OF FATHER (city or town) Hudson (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Dena Hoot.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Father. Walter Prasecki. (Address)

15 Filed ..... 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1927, to Oct. 9, 1927, that I last saw h[illegible] alive on Oct 9, 1927 and that death occurred, on the date stated above, at 10-00 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. T. Culbreath M. D.

, 19 (Address) 721 S. Ellwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery — DATE OF BURIAL 10/10 1927

20 UNDERTAKER William Cook — ADDRESS SOLE Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26296

CERTIFICATE OF DEATH.

129

E 26296
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Myrtle Ave ST., 17-24 WARD)

2-FULL NAME Lewis Benjamin Morris

(a) RESIDENCE NO. 1213 Myrtle Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Morris

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lelia Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Annie Morris
(Address) 1213 Myrtle Ave.

15 Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10—7— 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1927, to Oct 7th, 1927, that I last saw him alive on Oct 7th, 1927 and that death occurred, on the date stated above, at 4.0 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (Uremia)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Jno Carper, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 10 1927
20 UNDERTAKER Samuel P. Hensley	ADDRESS 1 E Eutaw

TIONS is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26297

CERTIFICATE OF DEATH

179 E 26297

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Autry N

(a) RESIDENCE NO. Morgan College, Hillen Rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May-13-1904

7 AGE: Years 23 Months 4 Days 27

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Berlin, Md

(State or country)

PARENTS

10 NAME OF FATHER Isaac Henry Sr.

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Hester Mullen

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Samuel H. Carter

(Address) Morgan College

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Sunday Oct 9th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 1927, to Oct 9th 1927, that I last saw h alive on Oct 8th 1927, and that death occurred, on the date stated above, at 9.05 a.m.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

Contributory cause unknown

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Morgan College

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1927 (Address) 324 N. Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Berlin Md

Date of Burial: 10 1927

20 UNDERTAKER: Edmund Abernethy

ADDRESS 7[illegible] N Eutaw

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26298

89

E 26298 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Esplanade Apts St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sigmund K. Stahlheimer

(a) RESIDENCE NO. Esplanade Apts St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma K. Stahlheimer

6 DATE OF BIRTH (month, day, and year): April 11 1866

7 AGE — Years: 61 Months: 5 Days: 27

IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stationer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Kaufman Stahlheimer

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Hahnemann

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs. Sigmund Stahlheimer

(Address) 2714 Eutaw Place

15 Filed ____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct 8 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1927, to Oct 8, 1927.

that I last saw h.. alive on Oct 8, 1927.

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Leuf, M. D.

Oct 10 1927 (Address) Temple Gardens

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Lombard Cemetery — Date of Burial: Oct 10 1927

20 UNDERTAKER: C. Ahrens & Co. — ADDRESS: 2432 Eastern Ave

very important. See instructions on back of certificates. Classified List of OCCUPATION IS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26299

CERTIFICATE OF DEATH.

113 V

E 26299

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No.) 614 Burgundy Alley St. 22-30 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Pritchett

(a) RESIDENCE NO. 614 Burgundy Alley Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 19 - 1927

7 AGE — Years: — Months: 8 — Days: 20 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: John Pritchett

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Pa

12 MAIDEN NAME OF MOTHER: Vergie Acree

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Vergie Pritchett

(Address) 614 Burgundy al

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows: Intestinal Rickets

Duration yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) E Davenport

Duration yrs. mos. ds.

(Signed) ..... M. D.

(Corner)

Oct 10, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — Date of Burial: Oct 10 1927

20 UNDERTAKER: John H. Toadvine — ADDRESS 1037 Druid Hill

very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26300

CERTIFICATE OF DEATH.

185 E 26300

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 Ridgewood Ave ST., 15-21 WARD) 7-REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Kohlhepp

(a) RESIDENCE NO 1929 Ridgewood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Kohlhepp

6 DATE OF BIRTH (month, day, and year) April 23-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Police Dept

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER George Kohlhepp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore. Md

12 MAIDEN NAME OF MOTHER Elizabeth Bleecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

PARENTS

14 Informant Mrs Rosie Kohlhepp
(Address) 1929 Ridgewood Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 9- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Fall

Cerebral Hemorrhage

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) G. E. Brady, M. D.
(Coroner.)
11 7 1927 (Address) 143 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Oct 12- 1927
20 UNDERTAKER Wm J Tickner & Sons	ADDRESS Mt Pa Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 26301 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26301

CERTIFICATE OF DEATH. 99-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 Garrison Ave St. [illegible] Ward 25-13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Sander

(a) RESIDENCE. No. Hillis Ferry Rd. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 1 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Y.W.C.A. work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Albrecht Sander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Catherine Craig 837 Edmondson Ave.

15 Filed Oct 19 27 Registrar R.U.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4 1927, to Oct 7 1927.

that I last saw her alive on Oct 7 1927.

and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows: Chronic bronchitis with asthma, and myocardial insufficiency —

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Heavy cold

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hartzell Cole, M. D.

Oct 7 1927 (Address) 2207 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Oct 10 1927
20 UNDERTAKER	ADDRESS
Wm. Tucker & Sons	Norfolk

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26302

CERTIFICATE OF DEATH.

185 E 26302

1-PLACE OF DEATH

City of BALTIMORE: (No. Mir Hospital St., 4-30 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Drusmon

(a) RESIDENCE NO. Do not Know St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE

Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Do not know

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Do not Know
(State or country)

PARENTS

10 NAME OF FATHER Do not Know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not Know

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Catholic Charities
(Address) Cathedral & Franklin

15 Filed ..... 19 ..... R.H.H. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, Autopsy or Inquiry.)
thereon and from the evidence obtained by said Inquest
Injury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Accident Fall.
Fracture of Skull
(Duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Alcoholism
(Duration) yrs. mos. ds.

Oct 10 27 (Signed) G. H. Wades M. D.
(Coroner)
(Address) 143 N. Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos. ....ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — Date of Burial 10/10/1927

20 UNDERTAKER J. Posher Sons — ADDRESS 318 Light

very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26303 E 26303

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Druid Hill Av ST.; 14-18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Hall

(Residence in Baltimore: No. 1630 Druid Hill Av St.; 1 yrs., 1 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Sept 24, 1926 (Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Hall

11-BIRTHPLACE OF FATHER (State or Country), Penn

12-MAIDEN NAME OF MOTHER Marjorie Stuart

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Hall

(Address) 1630 Druid Hill Ave

15-

Filed ..... 191.. .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct - 9 - 1927 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct-7- 1927, to Oct-9- 1927, that I saw him alive on Oct-9- 1927, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Enteritis

(Duration) 2 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 3 ds.

(Signed) J B Hughes M. D.

Oct 9, 1927 (Address) 413 S. Paca St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Calvary East DATE OF BURIAL, 10-10 1927

20-UNDERTAKER, Geo. L. Gelbert ADDRESS, 1735 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26304

CERTIFICATE OF DEATH.

161-001 E 26304

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1628 S. Charles ST., 23-32 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Paul Houck (6½ mos)

(a) RESIDENCE NO. 1628 S Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 6½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Oct 8, 1927

7 AGE	Years	Months	Days	If LESS than 1 day 6½ hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) — —

(c) Name of employer — —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Walter W Houck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Minnie A Pfaff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Walter W. Houck
(Address) 1628 S. Charles St.

15 Filed , 19 K.M.L., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1927, to Oct. 9, 1927, that I last saw him alive on Oct. 8, 1927, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. — mos. 6½ hours ds.

CONTRIBUTORY (Secondary) — —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Finding

(Signed) Harry Weibel, M. D.

10/9, 1927 (Address) 24-1226 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 10 1927

20 UNDERTAKER: Frid. A. Schaub — ADDRESS: 701 Hanover St

4

Spec.—1-10-21—M&T—1500 Bks.

E 26305 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 26305

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 S. Charles ST., 23-32 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Houck (5½ mos)

(a) RESIDENCE No. 1628 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ½ hour How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) Oct 8th "—1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	½ hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Walter W. Houck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Minnie A. Pfaff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Walter W. Houck

(Address) 1628 S. Charles St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8 .1927, to Oct 8 .1927, that I last saw her alive on Oct 8 .1927., and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

premature birth

(duration) yrs. mos. ½ hour ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical finding

(Signed) Harry Weibel M. D.

10/9. 1927 (Address) 24-1226 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Oct. 10th 1927

20 UNDERTAKER Fred C. Kalmeyer & Son — ADDRESS 703 Hanover

FROM A VERY IMPORTANT: See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26306

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 26306

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8230 Ostend ST., 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Creek.

(a) RESIDENCE No. 8230 Ostend ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col.	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Creek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Elizabeth Creek.
(Address) Annapolis Md

15 Filed . 19 .. Kelly Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-1927

17 I HEREBY CERTIFY, That I attended deceased from 10-4-, 1927, to 10-9-, 1927, that I last saw h alive on 10-8-, 1927 and that death occurred, on the date stated above, at 8,45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulate

(duration) 22 ont know. yrs. mos ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jr D Hanging M. D.

10-10-1927 (Address) 611- n. Chas.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon — DATE OF BURIAL Oct. 10 1927

20 UNDERTAKER Mrs R.G. Elliott — ADDRESS 1725 Ashland ave

Spec.—1-12-23—M&T—500 Blks.

E 26307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 E 26307

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 53 N. Carolina ST., 6-9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Porter

(a) RESIDENCE NO. 53 N. Carolina ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hawkins.

6 DATE OF BIRTH (month, day, and year) 9-10-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS

10 NAME OF FATHER Richard Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Rachel Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant Rev. Hendershott (Address) 53 N. Carolina

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7- 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-4-, 1927, to 10-7-, 1927, that I last saw h[illegible] alive on 10-7-, 1927 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. H. Cargile, M. D.

10-10-1927 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Oct. 19 1927

20 UNDERTAKER Wm. R. G. Elliott — ADDRESS 1725 Ashland Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26308

CERTIFICATE OF DEATH.

31 E 26308

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 515 S. Patterson Park Ave ST., WARD 1-3

2-FULL NAME Josephine Kuc.

(a) RESIDENCE NO. 515 S. Patt. Park Ave. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. Person 1902.

7 AGE: Years 25 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tailoring
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Antoni Kuc

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Nowakowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Antoni Kuc 515 S. Patt. Park Ave

15 Filed ....., 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1927, to Oct. 7, 1927, that I last saw her alive on Oct. 7, 1927, and that death occurred, on the date stated above, at 10 PM m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis (with cavitation on right side)

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lippy, M. D.

, 19 (Address) 1932 S Patterson Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: Oct 11 1927

UNDERTAKER: J. W. Gazenski — ADDRESS: 1930 Fleet St.

Spec.—1-12-23—M&T—500 Bks.

E 26309 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26309

CERTIFICATE OF DEATH.

73

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4660 Fernwood ave WARD) 27-48

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph W. Kimball

(a) RESIDENCE NO. 4660 Fernwood av ST. Green WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia A. Kimball.

6 DATE OF BIRTH (month, day, and year) Jan 15 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	59.	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machin

(b) General nature of industry, business, or establishment in which employed (or employer) Hand.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph J. Kimball.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Julia A. Clancy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant James E. Kimball

(Address) 4660 Fernwood ave

15 Filed , 19 Registrat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 | 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1927, to Oct 7, 1927, that I last saw h~~im~~ alive on Oct 7, 1927, and that death occurred, on the date stated above, at 12 P m

The CAUSE OF DEATH* was as follows:

Myelitis

(duration) 2 weeks yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan, M. D.

Oct 10, 1927 (Address) 5104 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct. 11 1927.

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford ave

Spec.–7-17-26—A Co.—200 Bks.

Harry Bangs

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26310

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St.. 16-68 Ward)

2-FULL NAME Harry Bangs

(a) RESIDENCE NO. 2202 W. Lanvale St Ward
(Usual place of abode)

Length of residence in city or town where death occurred 7yrs. mos. ds.

(If non-resident give city or town and State)
How long in U. S. if of foreign birth? yrs. mos. ds.

101-081

E 26310

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 21, 1882

7 AGE — Years: 45 Months: 8 Days: 19

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Bangs

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Edith Zerwick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Mrs Emma V. Bangs
(Address) 2202 W Lanvale St

15 Filed ..... (m. 19 .....
per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-10-'27 19

17 I HEREBY CERTIFY, That I attended deceased from 10-7-'27 19 , to 10-10-'27 19 ,
that I last saw him alive on 10-10-'27 19 .
and that death occurred, on the date stated above, at 1 a.m.
The CAUSE OF DEATH* was as follows:

Pneumonia, lobar

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

(Delirium Tremens) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Edw Johnston M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — Date of Burial: Oct 12 1927

20 UNDERTAKER: George J. Smith — ADDRESS 1532 Hollins

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26311 ✓ **E 26311**

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 7-13

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard James

(a) RESIDENCE NO. 522 N. Wolfe ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-23-27

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	8 months	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 9, 1927, that I last saw h alive on Oct 9, 1927, and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia left lower lobe
Multiple pulmonary abscess
? Erosion into bronchus c massive hemorrhage

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) Lyman Wells, M. D.

10-19-1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodberry Cemetery

DATE OF BURIAL Oct 12 1927

20 UNDERTAKER Clarence H. Johnson

ADDRESS [illegible]

OCT 27 C HAMPSON JOHNS M D

Spec.–7-17-26—A Co.—200 Bks.

E 26312

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 26312

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jones

(a) RESIDENCE NO. 122 Penna St. 17-24 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 43 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (City or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sherlock Wright

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Baltimore City H.P
(Address) Records

15 Filed ..... , 19 .....

Registrar

ICPM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 19 27

17 I HEREBY CERTIFY, That I attended deceased from 6-17- 1927 to 10-9- 1927

that I last saw him alive on Oct 9 1927

and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH was as follows:

Rheumatic Cardio Vascular disease - myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Smear

(Signed) Blood M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Albans Cemetery

Date of Burial 10-10 1927

20 UNDERTAKER Daniel Lester, Jr.

ADDRESS

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.-7-17-26—A Co.—200 Bks.

E 26313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26313

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. ALTIMORE CITY HOSPI[illegible] St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celestia gent Brown

(a) RESIDENCE NO. 21 S. Bond St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 30 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Virginia

PARENTS

10 NAME OF FATHER: James Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Hannah ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Virginia

14 Informant

(Address): ALTIMORE CITY HOSPITAL

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/5/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1927 to Oct. 8, 1927, that I last saw her alive on Oct. 8, 1927 and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

Hypertension

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General Exam.

(Signed) C. Holmes Boyd, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Auburn — Date of Burial 10-12-27 19

20 UNDERTAKER: Chas. A. Chickerson — ADDRESS 1327 E. Hampson

very important. See instructions on back of certificates.

Cor—12-9-26—A Co.—200 Bks.

Brogan

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26314

CERTIFICATE OF DEATH.

E 26314

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1317 Homewood Ave St., 9-18 Ward)

2-FULL NAME Joseph S. Brogan

(a) RESIDENCE NO. 1317 Homewood Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7/1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	0	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna R.R.

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John G. Brogan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah H. Harris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. Jane H. Brogan
(Address) 1317 Homewood Ave

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Influenza

(duration) 5 yrs yrs. mos. ds.

(Signed) J. C. H. Wales M. D.
(Coroner)

19 (Address) 10-18-27 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial Oct 12, 1927

20 UNDERTAKER Elmer W. Conklin ADDRESS 914 E. Eager St

Very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

E 26315

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26315

CERTIFICATE OF DEATH.

159-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 S Chester St Hosp ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Freeburn Child (unknown) 26-36

(a) RESIDENCE NO. N 76 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/2/29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed , 192 RRH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 192 7

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: (1) Asphyxia

(duration) Instan mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

(Signed) 10/7/27 G Hedges, M. D.

(Coroner) 192 (Address) 143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL OCT 11 192

20 UNDERTAKER — ADDRESS

G. HAMPSON JONES, M. D.
UNIVERSITY OF MARYLAND
DEMONSTRATOR OF ANATOMY

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 26316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26316

REGISTERED NO. [redacted]

1-PLACE OF DEATH

City of BALTIMORE: (No. 541 Walnut Ave. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. [redacted]

(a) RESIDENCE NO. 541 Walnut Ave. St. 17 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
[redacted]	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Ohio

(c) Name of employer General

9 BIRTHPLACE (city or town) Pa. 8 [illegible]

(State or country) Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) [illegible]

(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible]

(State or country)

14 Informant [illegible]

(Address) [illegible]

15 Filed....., 19.....

[illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an [redacted] (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said [redacted] (Inquest, autopsy or inquiry.) find that said deceased came to [redacted] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) two days Pleurisy

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. J. Manning M. D.

(Coroner)

Oct. 8 192 7 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Date of Burial OCT 10 1927 19

20 UNDERTAKER [redacted] ADDRESS [redacted]

very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND

Cor.—12-9-25—A Co.—200 Bks.

Simpson

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 26317

CERTIFICATE OF DEATH.

159-002

E 26317

REGISTERED NO._____

(If death occurred in hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 22 Ward)

2-FULL NAME Leroy Simpson

(a) RESIDENCE NO. 1023 N. Mount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24th 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant M. W. Tobin

(Address) Penna. Ave

15 Filed....., 19 Dec 27 1927 ARH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen Ovale

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. Bruce Price M. D.
(Coroner)

Feb 28, 19 27 (Address) 25 W. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial Mar 1 19 27

20 UNDERTAKER ADDRESS

very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26318

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26318

CERTIFICATE OF DEATH.

161-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1405 Pressman St. St., 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Baby Boy Jessie

(a) Residence No... 1405 Pressman St. St.,..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored.

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 9, 1927

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or. 5 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Boykin Jessie

11-BIRTHPLACE OF FATHER (city or town) Bennettsville (State or Country), S.C.

12-MAIDEN NAME OF MOTHER, Lexie Pierce

13-BIRTHPLACE OF MOTHER (city or town) Bennettsville (State or Country), SC.

14- (Informant).....

(Address).....

15- Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 9, 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 9, 1927 to Oct 9, 1927.

that I last saw h[illegible] alive on Oct 9, 1927.

and that death occurred, on the date stated above, at 4.35 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

Congenital atelectasis

.....(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

.....(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) Dwight Reynolds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, ..., 19....

20-UNDERTAKER. ADDRESS

UNIVERSITY OF MARYLAND
C. HAMPSON JONES, M.D.
OCT 10 1927

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26319

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 26319

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 Vine Street St., 18-26 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Parker.

(a) Residence No. 920 Vine Street St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black.

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 7, 1927

7-AGE. yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Aron Parker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Norfolk Va

12-MAIDEN NAME OF MOTHER, Emma Carr

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Washington D.C.

14-

(Informant)

(Address)

15-

Filed , 192

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 9, 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1927 to Oct 9 1927, that I last saw h[illegible] alive on Oct 9 1927, and that death occurred, on the date stated above, at 1.15 a m

The CAUSE OF DEATH* was as follows:

Maternal Syphilis

Congenital Atelectasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy exam

(Signed) Dwight Reynolds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, , 19

20-UNDERTAKER. ADDRESS

UNIVERSITY OF MARYLAND

OCT 10 1927

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26320

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26320

CERTIFICATE OF DEATH.

161-001

Registered No. 11-15

1-PLACE OF DEATH

City of BALTIMORE: (No. 1116 Guilford Ave St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Millionie

(a) Residence No. 1116 Guilford ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 9, 1927

7-AGE ... yrs. ... mos. ... ds.

If LESS than 1 day, 3 hrs. or. 40 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md (State or Country),

PARENTS.

10-NAME OF FATHER, Gus Millionie

11-BIRTHPLACE OF FATHER (city or town) Athens (State or Country), Greece

12-MAIDEN NAME OF MOTHER, Mary Keller

13-BIRTHPLACE OF MOTHER (city or town) Pittsburgh (State or Country),

14- (Informant)

(Address) JOHNS HOPKINS HOSPITAL

15- Filed ... 192... Registrar.

APR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 9, 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 9, 1927, to Oct 9, 1927, that I last saw her alive on Oct 9, 1927, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

Congenital Atelectasis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy exam

(Signed) Dwight Reynolds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ... 19...

20-UNDERTAKER, Baltimore Health Dept.

ADDRESS

OCT 10 1927

Spec.—1-12-23—M&T—500 Bks.

E 26321 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26321

CERTIFICATE OF DEATH. 16-002 26-37

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Dorothy Daniel

(a) RESIDENCE NO. 3711 Eng ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced (HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-27

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Howard Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Thelma Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Johns Hopkins Hospital (Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1927, to Oct. 10, 1927, that I last saw her alive on Oct. 10, 1927, and that death occurred, on the date stated above, at 5 10 m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) ..... yrs. ..... mos 28 ds.

CONTRIBUTORY (Secondary) Pertussis. Bronchopneumonia. Otitis media. (duration) ..... yrs. ..... mos. 25 15 ds.

18 Where was disease contracted if not at place of death? ..... At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Lyman Wells, M. D.

Oct 10, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthias Cem.

DATE OF BURIAL Oct 12 1927

20 UNDERTAKER Wendell J. Hoppel

ADDRESS 311 S. Eden St

Spec.-7-17-26—A Co.—200 Bks.

E 26322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26322

31

REGISTERED NO. 3-4

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Allen

(a) RESIDENCE NO. 6 Weisinfield Court St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE 55 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) BALTIMORE CITY HOSPITALS

15 Filed , 19 NRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-8, 1927, to 10-8, 1927

that I last saw him alive on 10-8, 1927

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) C. J. Hutchens Burgel, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Ashury Cemetery Oct 11. 1927.

20 UNDERTAKER — ADDRESS

Wendell J Hysped 311 N Eden St.

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.– 200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26323

CERTIFICATE OF DEATH

161-001

E 26323

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2005 E. Pratt St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Wrbes

(a) RESIDENCE NO. 2005 E. Pratt St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 8 1927.

7 AGE Years Months Days

IF LESS than 1 day 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Edward H Wrbes

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Helen Simmons

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Edward Wrbes

(Address) 2005 E. Pratt St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1927, to Oct. 8, 1927, that I last saw him alive on Oct. 8, 1927, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity birth

(7 mo.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Brent Tennyson M. D.

10/8, 1927 (Address) 2405 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthias — Date of Burial Oct 10 1927

20 UNDERTAKER Wendell L Lippel — ADDRESS 311 N Eden St

OCT 10 1927 HAMPSON JONES, M. D.

very important. See instructions on back of certificates. CAUSE OF DEATH IS

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26324

E 26324

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Baltimore City Hospitals St. (T.B.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Queen

(a) RESIDENCE NO. 252 S. Dallas st. St. 2-4 Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington

(State or country) Distric of Columbia

PARENTS

10 NAME OF FATHER John Queen

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Alice Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from June 24, 19 27 to October 7, 19 27

that I last saw her alive on October 7, 19 27

and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) E. Madden M. D.

10-8- 19 27 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Eastern Cemetery	Oct 11. 1927
20 UNDERTAKER	ADDRESS
Wendell J Hopped	311 S Eden

very important. See instructions on back of ... k of certificates. ... be properly classified. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

E 26325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26325

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 S. Mount ST., 19th WARD)

REGISTERED NO. 19-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Agnes Linsenmeyer

(a) RESIDENCE No. 122 S. Mount St ST., 19th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

5a If married, widowed, or divorced (or) WIFE of Frank J. Linsenmeyer

6 DATE OF BIRTH (month, day, and year) Feb 11, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Adam Stengel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Ursula Veith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary Ursula Linsenmeyer

(Address) 122 S. mount St.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 8, 1927

17

I HEREBY CERTIFY, That I attended deceased from ~~October~~ Sept 27 1927. to October 8, 1927.

that I last saw her alive on October 7, 1927.

and that death occurred, on the date stated above, at 8.55 m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) 0 yrs. 0 mos 11 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) 0 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1319 Light St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	10/11 19 27

20 UNDERTAKER J. A. Klaffke

ADDRESS Lombard & Eutaw Sts.

TION IS very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26326

E 26326

CERTIFICATE OF DEATH

113

REGISTERED NO. 20-69

1-PLACE OF DEATH

City of BALTIMORE: (No. 2712 Lauraetta Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeannette Ray Marshall,

(a) RESIDENCE NO. 2712 Lauraetta Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ****

6 DATE OF BIRTH (month, day, and year)
June 20.1927

7 AGE	Years	Months	Days
	---	3	19

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Franjlin L.Marshall,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Alma D.Floyd,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Franklin D.Marshall,
(Address) 2712 Lauraetta Ave.

15 Filed ....., 19.....

1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 9.1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 8th, 1927, to Oct 9th, 1927, that I last saw h.. alive on Oct 9th, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lue meningitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symps

(Signed) H. R. Riemer, M. D.

10/10 1927 (Address) 3921 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Oct 11 1927

20 UNDERTAKER Robt J. Little

ADDRESS 3921 Edmondson

very important. See instructions on back of certificates. Full statement of OCCUPATION is

Spec. -7-17-26—A Co.—200 Bks.

E 26327

(Ashcraft)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 26327

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St.. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Odie Ashcraft

(a) RESIDENCE NO. 1610 Guilford Ave Ward Georgia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louise Ashcraft

6 DATE OF BIRTH (month, day, and year): Jan 6th 1893

7 AGE: Years 34 Months 9 Days 4

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer): 063

(c) Name of employer

9 BIRTHPLACE (city or town) Atlanta Ga

(State or country)

PARENTS

10 NAME OF FATHER J. Hasheraft

11 BIRTHPLACE OF FATHER (City or town) Atlanta Ga

(State or country)

12 MAIDEN NAME OF MOTHER Lilla Sipes

13 BIRTHPLACE OF MOTHER (city or town) Atlanta Ga

(State or country)

14 Informant Blasie ashcraft

(Address) 1217 N Calvert St

15 Filed . 19 Registrar

DPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10-10-'27

17 I HEREBY CERTIFY, That I attended deceased from 10-4-'27 . 19 . to 10-10-'27 19 .

that I last saw h.. alive on 10-10-'27 19 .

and that death occurred, on the date stated above, at 3 40 a.m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Septicemia

Broncho-pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no yes

What test confirmed diagnosis? Physical findings

(Signed) Embalmer M. D.

. 19 (Address) Mercy hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Atlanta Ga.

Date of Burial: 10/10 1927

20 UNDERTAKER: Robert Brookeson

ADDRESS: Calhoun Hollins

very important. See instructions on back of

1927 HARRISON BOOKS

Spec.–7-17-26—A Co.—200 Bks.

E 26328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26328

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maurice Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Strobel

(a) RESIDENCE NO. Richard Harford Co. Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER John Strobel

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER C. Hoffnecker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hospital Record

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/8 1927, to 10/10 1927, that I last saw h[illegible] alive on 10/10 1927, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Lymphus - Sarcoma

(duration) yrs. 6 mos. [illegible] ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Lewis Allen Taylor, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Harford Co. The Mountain Cemetery	Oct 12th 1927
20 UNDERTAKER	ADDRESS
Chas E. Homberger	Benson Md.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26329

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2117 Boyd St., 20th Ward. 129

REGISTERED NO. 20169

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Hoffmann

(a) RESIDENCE No. 2117 Boyd St. 20th Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX — Female

4 COLOR OR RACE — White

5 Single, Married, Widowed, or Divorced, (write the word) — Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Earl Hoffmann

6 DATE OF BIRTH (month, day, and year) — Oct 20th 1854

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
72	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) — Hungary

PARENTS

10 NAME OF FATHER — Casper Hoffmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Hungary

12 MAIDEN NAME OF MOTHER — Valencsan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Hungary

14 Informant — Albert Hoffmann

(Address) 2117 Boyd St

15 Filed , 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) — Oct 9th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to Oct 9, 1927, that I last saw h alive on Oct 9, 1927, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows: —

Chronic Nephritis

Chronic Valvular Heart Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Keller Hemmeter M. D.

10/10/27 (Address) 7000 Holland St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Western Cemetery — DATE OF BURIAL Oct 12th 1927

20 UNDERTAKER — F. B. Weyant — ADDRESS 830 W. Pratt St

Spec.—1-12-23—M&T—500 Bks.

E 26330

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26330

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mrs Hope Retreat

REGISTERED NO. 28-163

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morgan L. Brent

(a) RESIDENCE NO. Mrs Hope Retreat ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug. 10-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	55	2	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerical
(b) General nature of industry, business, or establishment in which employed (or employer) Dept of Justice
(c) Name of employer Government

9 BIRTHPLACE (city or town) Charles Co.
(State or country) Md

PARENTS

10 NAME OF FATHER George Brent

11 BIRTHPLACE OF FATHER (city or town) Chas. Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Merrick

13 BIRTHPLACE OF MOTHER (city or town) Chas Co.
(State or country) Md.

14 Informant Mrs Hope Reynolds
(Address) Mrs Hope Retreat

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1925, to Oct 10, 1927.
that I last saw her alive on Oct 10, 1927,
and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:
Enteritis and Marasmus.
(Delusions and Hallucinations)

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Dementia Praecox

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill, M. D.

, 19 (Address) Mrs Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. | DATE OF BURIAL Oct. 10 1927

20 UNDERTAKER Stewart & Mowen Co | ADDRESS 1080 N. Hoyt Ca

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26331

14-001

REGISTERED NO. E 26331

1-PLACE OF DEATH

City of BALTIMORE: (No. 908 Penna. ave. St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Graves

(a) RESIDENCE NO. 908 Penna. ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Grave

6 DATE OF BIRTH (month, day, and year): about 1882

7 AGE: Years 45; Months; Days; IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: General

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Edward Graves

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Estella Gude

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Martha Graves

(Address): 908 Penna. ave.

15 Filed ....., 19 ..... R.R.C.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 8, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) senile tissue

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Oct. 10, 1927 (Address) 2572 Eutaw pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial Oct 11 1927

20 UNDERTAKER: Daniel Easton ADDRESS E/6 Saratoga

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

E 26332

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 E 26332

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. [illegible] ST., 2 WARD)

REGISTERED NO. [illegible]
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Penny Lennon

(a) RESIDENCE No. 205 W. Montgomery ST. [illegible] WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., If of foreign birth? [illegible] yrs. [illegible] mos. [illegible] ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wade Almond

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Matilda Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant [illegible] (Address) [illegible]

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1927, to Oct. 10, 1927, that I last saw her alive on Oct. 10, 1927, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.
Subacute Nephritis & Uremia.
Hepatitis

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X ray Bilateral Autopsy

(Signed) Lyman Meeks, M. D.

Oct. 10, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: Oct 11 1927

20 UNDERTAKER: Vernon Easton ADDRESS 916 Park

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26333

CERTIFICATE OF DEATH

31

E 26333

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1003 Jenkins alley 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Thompson

(a) RESIDENCE NO. 1003 Jenkins alley Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1906

7 AGE: Years 21 Months Days IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) md

PARENTS

10 NAME OF FATHER John Campbell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Gibbs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Lucy Campbell

(Address) 1003 Jenkins alley

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 — 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 1927, to Oct 15 1927, that I last saw h[illegible] alive on 10th Oct 1927, and that death occurred, on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows: Phthisis Pulmonalis

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted Unknown

if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 119 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cem — Date of Burial Oct 11 — 1927

20 UNDERTAKER: Dennis Burton — ADDRESS 916 Eutaw ave

very important. See instructions on back of ... is ... property cashier. Exam. statement of OCCUPATION is ... check of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY

Cor.—12-9-25—A Co.—200 Bks.

E 26334

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26334

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mt Hospital 11-27 Ward)

2-FULL NAME Elizabeth Jones

(a) RESIDENCE NO. 705 Fyeon St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Wed

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1901

7 AGE: Years 26; Months —; Days —; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore md

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

PARENTS

14 Informant: Mrs C. E. Nickous

(Address) 770 W Franklin St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Duration) yrs. mos. ds.

(See Injury)

Signed (Duration) yrs. mos. 1 ds.

Dec 10, 1927 (Address) 1436 Bway (Coroner) M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Dec 11 1927

20 UNDERTAKER: Hamil Easter ADDRESS 916 Eutaw

very important. See instructions on back of certificate. EXACT STATEMENT OF OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26335

CERTIFICATE OF DEATH.

100-001 E 26335

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 Oxford St. 17-24 Ward

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Anthony Holmes

(a) RESIDENCE NO. 515 Oxford St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/7/27

7 AGE — Years | Months: 8 | Days: 2 | If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Boston

(State or country): Mass

PARENTS

10 NAME OF FATHER: Francis Holmes

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Mass

12 MAIDEN NAME OF MOTHER: Mary Wallace

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: mother

(Address) 515 Oxford St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/9/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/7/ 1927, to 10/9/ 1927, that I last saw him alive on 10/8/ 1927, and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Primary)

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. V. Hawkins, M. D.

10/9/ 1927 (Address) 912 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial Oct 11 1927

20 UNDERTAKER: Daniel Easter & Son ADDRESS 916

Spec.—1-12-23—M&T—500 Bks.

E 26336

HEALTH DEPARTMENT—CITY OF BALTIMORE

n. CERTIFICATE OF DEATH.

119 E 26336

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1610 Fitzman ST., 15-21 WARD)

2-FULL NAME Alice Thomas Lane

(a) RESIDENCE NO. 1610 Fitzman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Lane

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 50; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Fitzman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: [illegible] Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Thomas Lane

(Address): 1610 Fitzman

15 Filed , 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/9 1927

17

I HEREBY CERTIFY, That I attended deceased from 9/10, 1927, to 10/9, 1927, that I last saw h[illegible] alive on 10/9, 1927 and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar abscess

Tuberculosis ?

Terminal Septicaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burton, M. D.

10/9, 1927 (Address) 2[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn DATE OF BURIAL: Oct 11th 1927

20 UNDERTAKER: Harris Easton ADDRESS 916 Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26337

CERTIFICATE OF DEATH.

89 E 26337

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Ellamont ST., 16-17 WARD)

2-FULL NAME Amanda E. Conway

(a) RESIDENCE NO. 1712 Ellamont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of: Jesse Conway

6 DATE OF BIRTH (month, day, and year): Aug. 16 1856

7 AGE: Years 71 Months 1 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Co. Md.

12 MAIDEN NAME OF MOTHER: Hester Arm Drumey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co. Md.

14 Informant: Walter Conway

(Address): 1712 Ellamont Ste

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1927, to Oct 9 1927,

that I last saw h~~er~~ alive on Oct 9, 1927,

and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis- one attack at 8 P.M. Oct 8/27 1/2 hour m. or l.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Aortitis- Brief slight attacks unknown- on occasions.

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pulse 50 last 24 hrs. 1 Heart block

(Signed) Chas. E. Parker, M. D.

19 (Address) 3123 N. Howard

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Oct 11 1927

20 UNDERTAKER: Chas. E. Francis ADDRESS: 811 Madison

FROM is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

E 26338 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26338

CERTIFICATE OF DEATH

129

REGISTERED NO. 22-30

1-PLACE OF DEATH

City of BALTIMORE: (No. 116 W. Perry St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Wright (Johnson)

(a) RESIDENCE NO. 116 W Perry St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. - mos. - ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) -1880

7 AGE: Years 47 Months - Days -

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 97

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedores

(c) Name of employer Sugar Refinery

9 BIRTHPLACE (city or town) Petersburg

(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Lora Henson

(Address) 111 W. Perry St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/8 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/5 1927 to 10/8 1927

that I last saw h.. alive on 10/8 1927

and that death occurred, on the date stated above, at 3:20 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension & Chr Nephritis (duration) unk yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hypertension 140

(Signed) Dr. Saunders M. D.

10/9 1927 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

20 UNDERTAKER — ADDRESS

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 26339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 26339

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 404 So. Pulaski St. 20-69 Ward)

2-FULL NAME Martin Spangenberg

(a) RESIDENCE NO. 404 So. Pulaski St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 9th 1927

7 AGE — Years — Months — Days — IF LESS than 1 day hrs. or min. 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Geo. Spangenberg

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Anna M. Zilonka

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Geo. Spangenberg

(Address) 404 So. Pulaski

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 9th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, at my office (Inquest, at my office or place of inquiry.) thereon and from the evidence obtained by me at Inquest and from the records of this office (Inquest, autopsy or inquiry.) find that said deceased came to h Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature 1½ hours Birth

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D.

Oct 10th 1927 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See Instructions.) Balto Md

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Gethsemane Cemetery Date of Burial Oct 11 1927

20 UNDERTAKER C. H. Whitfield ADDRESS 1850 W Baltimore St.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 26340 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26340

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 S. Thirteenth ST., 26 WARD)

2-FULL NAME Bernardina Dietz.

(a) RESIDENCE No. 502 S. Thirteenth ST., 26 WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1/4-001 26-37

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John G. Dietz

6 DATE OF BIRTH (month, day, and year) July 7th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Francis J. Bockelage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Christina Schorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Dietz (Son)
(Address) 1301 N. Luzerne Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 , 1927, to Oct 9 , 1927, that I last saw her alive on Oct 8 , 1927 and that death occurred, on the date stated above, at 8A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B Tatlow M. D.

(19 27 Address) 315 S. Highlandtown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery DATE OF BURIAL Oct 12th 1927

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Howard

THIS is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 2...

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 26341

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 N. Gaulay St., 7-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonie Trittt-Trutnovsky

(a) RESIDENCE NO. 614 N. Gaulay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Trutnovsky

6 DATE OF BIRTH (month, day, and year) May 11/1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	60	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia

(State or country)

PARENTS

10 NAME OF FATHER — Intaland

11 BIRTHPLACE OF FATHER (City or town) Bohemia

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bohemia

14 Informant Mrs Minora Krause

(Address) 320 N. Gaulay St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 19.., to Oct 9, 19 27

that I last saw h.. alive on Oct 9, 19 27

and that death occurred, on the date stated above, at 9 15 pm.

The CAUSE OF DEATH* was as follows:

Apoplexy Hemiplegia

Arteriosclerosis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Krause, M. D.

, 19 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial 10/13 1927

20 UNDERTAKER Chas Henry ADDRESS 2046 Gilmore St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 26342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 E 26342

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 26-42 Ward)

2-FULL NAME Clorieda Moore

(a) RESIDENCE NO. 9 Rockdale Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo. H. Moore

6 DATE OF BIRTH (month, day, and year) May 31/1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 3

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer At home

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frederick Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Kkkkk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Ada Whitley

(Address) 9 Rockdale Ave

15 Filed 19 R.C.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Oct 9/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis with Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronco-pneumonia

(duration) yrs. mos. ds.

(Signed) J. H. Mackall M. D.
(Coroner)

19 (Address)
10/10/27 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk Date of Burial 10/13 1927

20 UNDERTAKER Philip Herring ADDRESS 2010 Eutaw St

very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26343

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26343

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1429 John Street St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Francis O'Hara

(a) Residence No. 1429 John Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 1, 1927

7-AGE. ....yrs. ....mos. ....ds.

If LESS than 1 day, 18 hrs. or 2 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) 1429 John St. (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William O'Hara

11-BIRTHPLACE OF FATHER (city or town) Ballina Ireland (State or Country),

12-MAIDEN NAME OF MOTHER, Margaret Estella Brooks

13-BIRTHPLACE OF MOTHER (city or town) Ashland Va (State or Country),

14- (Informant).....

(Address).....

15- Filed ....., 19?. ....., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 2 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 2, 1927, that I last saw him alive on Oct 2, 1927, and that death occurred, on the date stated above, at 10 09 a m

The CAUSE OF DEATH* was as follows:

Prematurity

Congenital Atelectasis

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Phy exam

(Signed) Knight Reynolds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, ..., 19....

20-UNDERTAKER. ADDRESS

UNIVERSITY OF MARYLAND G. HAMPDEN JONES M. UNIVERSITY OF MARYLAND

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26344

CERTIFICATE OF DEATH

× 148 E 26344

1-PLACE OF DEATH Womans Hospital. REGISTERED NO.

City of BALTIMORE: (No. 14 St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Matilda Price

(a) RESIDENCE NO. Texas - Balto Co, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 Weeks ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. S. Price.

6 DATE OF BIRTH (month, day, and year) ?

7 AGE 32 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co

(State or country)

PARENTS

10 NAME OF FATHER Tom Tolmpson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant John W. S. Price

(Address) Texas - Balto Co. Md.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1927, to Oct. 10, 1927, that I last saw her alive on Oct. 10, 1927, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Nephritic Toxemia of Pregnancy

Full term Pregnancy

Mid-forceps delivery

(duration) 2 yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) ? yrs. ? mos. 1 hr. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of Oct. 10, 1927

Was there an autopsy? No

What test confirmed diagnosis? Blood Chem. Urinalysis

(Signed) H. H. Brock, M. D.

, 19 (Address) Womans Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerops, Balto Co., Md Date of Burial Oct. 13 1927

20 UNDERTAKER Wm. C. Brooks ADDRESS Sparks, Md

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26345 ✓ E 26345

E 26345

CERTIFICATE OF DEATH

162

REGISTERED NO. .....

1-PLACE OF DEATH Woman's Hospital. St. 14-20 Ward)

City of BALTIMORE: (No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Price

(a) RESIDENCE NO. 0 St. ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day 2½ hrs. or ..... min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER John W.S. Price

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country)

12 MAIDEN NAME OF MOTHER Mary Matilda Thompson

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.

(State or country)

14 Informant John W. S. Price, Owings Mills Md

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1927, to Oct 11, 1927.

that I last saw her alive on Oct 10, 1927.

and that death occurred, on the date stated above, at 6 30 A.M.

The CAUSE OF DEATH* was as follows:

Hemorrhagic disease of the new-born

(duration) ..... yrs. ..... mos. 1 hr. ds.

CONTRIBUTORY .....

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Prolonged clotting time

(Signed) H. H. Brack, M. D.

19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerrops, Balto Co., Md — Date of Burial Oct. 13 1927

20 UNDERTAKER Wm. C. Brooks — ADDRESS Sparks

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26346

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90

E 26346

REGISTERED NO.

City of BALTIMORE: (No. Hopkins Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris Marion Conaway

(a) RESIDENCE NO. 525 Bloom St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5/22

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or....min.
	5	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Nathaniel Conoway

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Glenora Clayton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Glenora Conaway

(Address) 525 Bloom St

15 Filed..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rheumatic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Bruce M. D.

(Coroner)

10-10-27 (Address) 508 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Oct 11 1927

20 UNDERTAKER Virginia A. Brooks ADDRESS 1463 N. Carey St

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26347

CERTIFICATE OF DEATH

99-002

REGISTERED NO. E 26347

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (T.B.) St., 1-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Havel

(a) RESIDENCE NO. 918 N. Bradford st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bohemia

PARENTS

10 NAME OF FATHER Mike Havel

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Marie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bohemia

14 Informant Hospital Records

(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 10, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 19 27, to Oct. 10, 19 27,

that I last saw him alive on October 10, 19 27,

and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Lung abscesses

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchiectasis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. Emmadler, M. D.

10-10 19 27 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — Date of Burial Oct 12 1927

20 UNDERTAKER August Pasch. — ADDRESS 2466 Ashland ave

very important. See instructions on back of certificate.

Cor.—12-9-26—A Co.—200 Bxs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26348

CERTIFICATE OF DEATH.

92 E 26348

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 6-9 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Price

(a) RESIDENCE NO. 1608 Mullikin St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Gus Price
11 BIRTHPLACE OF FATHER (city or town)
(State or country) MD.
12 MAIDEN NAME OF MOTHER Olivia Chase
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Wm. Price (Bro.)
(Address) 1603 Mullikan St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF BEATH (month, day, and year) Oct 9/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Thrombotic occlusion of left coronary artery.-Myocardial Infarcts (Autopsy at Hopkins)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. H. Mills (Coroner) M. D.

10-10-27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL national cemetery Date of Burial Oct 11 1927

20 UNDERTAKER Edward Bryan ADDRESS 1631 orleans st

Very important. See instructions on back of certificate. FORM APPROVED BY BUREAU OF OCCUPATION 18

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26349

CERTIFICATE OF DEATH.

31 E 26349

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1416 E. Mounment ST., (WARD) 10-13

2-FULL NAME Volia Cephus

(a) RESIDENCE NO. 1416 E. Mounment ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 28 1896

7 AGE — Years: 31 — Months: 7 — Days: 10 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED: House work

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Will Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Addie Cephus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Laura Dorsey

(Address): 1416 E. mounment st

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 27, to Oct 8 19 27

that I last saw her alive on Oct 8, 19 27

and that death occurred, on the date stated above, at 4.50 m

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

(duration) yrs. 1 mos 30 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Personal

(Signed) [illegible], M. D.

(Address) 5.8 [illegible] st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woods cemetery

DATE OF BURIAL: Oct 11. 1927

20 UNDERTAKER: Edward Bryan

ADDRESS: 1631 orleans st

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26350

CERTIFICATE OF DEATH

113 E 26350

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp. St., 12-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretta McDermott

(a) RESIDENCE NO. 429 N 23rd St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20 1926

7 AGE / Years Months Days 14.

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Frank Mc Dermott

11 BIRTHPLACE OF FATHER (City or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Anna Mc Dermott

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Father
(Address) 429 N 23rd St

15 Filed ..... 19 .. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 9, 1927, to Oct 9, 1927, that I last saw her alive on Oct 9, 1927, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Ulceration Colitis & Enteritis

(duration) yrs. mos 7 da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological & Bacteriological

(Signed) Edward C. Cuff M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Texas Md — Date of Burial 10/11/27

20 UNDERTAKER: George W. Janney Fulton Baltimore — ADDRESS

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 26351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO. E 26351

1-PLACE OF DEATH

City of BALTIMORE: (No. 723 S. Bethel St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Sokolowski

(a) RESIDENCE NO. 723 S. Bethel St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 15-1926

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John Sokolowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Stefania Banachowska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant (Address) Stefania Sokolowska 723 S. Bethel

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 19 27, to Oct 10, 19 27, that I last saw h.. alive on Oct 10, 19 27, and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Kysar M. D.

19 (Address) 801 E. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. Date of Burial: Oct 11 1927

20 UNDERTAKER: George A. Weber ADDRESS: 2205 Bank St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26352

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

161-00

E 26352

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 100 N. Bentalou ST., 20-67 WARD)

2-FULL NAME Baby Miller

(a) RESIDENCE NO. 100 N Bentalou ST.. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry M. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Marie Albrecht

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Harry M. Miller
(Address) 100 N Bentalou St

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9/27 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 3/27 , 19 , to Oct 9/27 , 19 ,

that I last saw him alive on Oct 4/27 , 19 ,

and that death occurred, on the date stated above, at 11 PM m.

The CAUSE OF DEATH* was as follows:

Premature Isolation

7 mo

(duration) yrs 7 mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hugo B Koll , M. D.

Oct 10/27 19 (Address) 1703 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 11 19 27

20 UNDERTAKER F. A. Schaaf & Son.

ADDRESS 703 Hanover St

FROM IS very important. See instructions on back of certificates.

Madison 4924

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26353

CERTIFICATE OF DEATH

49 V

E 26353 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1106 N. Monroe St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Schwartz

(a) RESIDENCE NO. 1106 N Monroe St. Ward Resident

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. ? mos. ? ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 77 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Schwartz

6 DATE OF BIRTH (month, day, and year): August 7 1837

7 AGE: Years 90 Months 2 Days 2 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town): Frankfurt

(State or country): Germany

PARENTS

10 NAME OF FATHER: Geo. Dominique

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Marie ? ? ?

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Mrs. A. Redner (Son)

(Address) 2806 W. Lanvale St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 9 19 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1 19 27 to Oct 9 19 27

that I last saw h.e.s. alive on October 9 19 27

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

probable (duration) 2 yrs. mos. ? ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) ..... yrs. ..... mos ..... ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? cystoscopy

(Signed) Darius A. Taggart M. D.

. 19 (Address) 1015 Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial Oct 12 1927.

20 UNDERTAKER: Stewart Mortuary Co. ADDRESS Balto.

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26354

CERTIFICATE OF DEATH.

18'-x004 ✓

E 26354

1-PLACE OF DEATH Pronounced at the

City of BALTIMORE: (No. South Baltimore General Hospital (Ward) 24-23

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard H. Sherbert.

(a) RESIDENCE NO. Marley, A. A. Co. Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs.---mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Married.

5a If married, XXXXXXXXXXXX HUSBAND of XXXXXXXXX Susan Sherbert.

6 DATE OF BIRTH (month, day, and year) April 1, 1890.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER John W. Sherbert.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Matilda Burke.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) A. A. Co. Md.

14 Informant Susan Sherbert. (wife)

(Address) Marley, A. A. Co. Md.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 8, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed about the body under a steam shovel by the breaking of a cable.
Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Hoke Kennard M. D.
(Coroner)

10/11 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Mountain Rd. A. A. Co. Md. Oct 8° 1927

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial: Oct 11, 1927

20 UNDERTAKER: Margaret S. Flynn ADDRESS: 1427 Light St.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 26355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

E 26355

1-PLACE OF DEATH

City of BALTIMORE: (No. 1-13 St., Ward)

2-FULL NAME Mary L. Schuler

(a) RESIDENCE NO. 1129 Park Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Schuler

6 DATE OF BIRTH (month, day, and year): Sept 11, 1891

7 AGE: Years 36 Months 1 Days 26 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): Medicine

(c) Name of employer: Self

9 BIRTHPLACE (city or town)

(State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joseph G Schuler

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary E Vogelgesang

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Pa

14 Informant (Address): Philip Schuler 218 S. Highland Ave

15 Filed..... 19 ..... Registrar ERK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — Date of Burial: 10/17 192

20 UNDERTAKER: Milton Cook — ADDRESS: 502 E North Ave

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26356 ✓ X 45 E 26356

REGISTERED NO. 11-24

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen'l Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Steinbock

(a) RESIDENCE NO. Arnold md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 21 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Steinbock

6 DATE OF BIRTH (month, day, and year) 3-12-1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Ger. George G.

(State or country)

PARENTS

10 NAME OF FATHER Henry Steinbock

11 BIRTHPLACE OF FATHER (City or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Friedman

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Mrs. Nora G. Steinbock

(Address) 4129 Forest Park Ave

15 Filed ....., 19 .....

Registrar

RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-10-27 19

17 I HEREBY CERTIFY, That I attended deceased from 9-19-27, 19..., to 10-10-27, 19...,

that I last saw h. alive on 10-10-27, 19...,

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows: Cerebral Thrombosis

..... (duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Mal-nutrition

..... (doration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 9-26-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) Md Gen'l Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem Date of Burial Oct 13 19

20 UNDERTAKER George J Smith ADDRESS 1532 Hollins St

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 26357

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26357

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH Balto. Md.

REGISTERED NO. 18-26

CITY OF BALTIMORE: (No. Nursery & Childs Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moy ~~Leon~~ Yuen Lee

(a) RESIDENCE NO. Nursery & Childs Hosp ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Chinese

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/21/1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1 year	7 mos.	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER -?-

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Mrs Mary Forehand

(Address) Schroeder & Franklin Sts

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 10, 1927, that I last saw her alive on Oct 10, 1927, and that death occurred, on the date stated above, at 3 30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes autopsy

What test confirmed diagnosis? ~~Blood~~ Findings

(Signed) Frederick J Ward, M. D.

, 19 (Address) 720 St Paul,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Oct 11 1927

20 UNDERTAKER George J Smith ADDRESS 1532 Hollins

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26358

CERTIFICATE OF DEATH.

185 E 26358

REGISTERED NO. 23-32

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) MMH Hospital St. (Ward)

2-FULL NAME Ethel L. Pro Fitt

(a) RESIDENCE NO. 1505 Race St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abel Profitt

6 DATE OF BIRTH (month, day, and year): 4/22/1887

7 AGE: Years 40 Months 2 Days 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): N.C

PARENTS

10 NAME OF FATHER: John Bailey

11 BIRTHPLACE OF FATHER (city or town)

(State or country): N.C

12 MAIDEN NAME OF MOTHER: Do Not Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Do Not Know

14 Informant: [illegible]

(Address): 926 Putnam Ave Brooklyn NY

15 Filed.....19.....

RHC Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.)

find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Fall

Central Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 1 ds.

Oct 10 1927 Signed) G E Wades (Coroner)

19 (Address) 1431 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: 10/11/1927

20 UNDERTAKER: J Posey Sons — ADDRESS: 1318 Eutaw

very important. See instructions on back of certificate. Last statement of OCCUPATION is

Spec.—7-17-26—A Co.—200 Bks.

E 26359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 26359

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1929 Fleet St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DANIEL B. WINIEWICZ,

(a) RESIDENCE NO. 1929 Fleet St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 28 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14-1927.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) MD.

PARENTS

10 NAME OF FATHER William Winiewicz,

11 BIRTHPLACE OF FATHER (City or town) Warwood,

(State or country) PA.

12 MAIDEN NAME OF MOTHER Lena Whyhouser,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,

(State or country) MD.

14 Informant William Winiewicz,

(Address) 1929 Fleet Street

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/8, 1927, to 10/10, 1927, that I last saw h[illegible] alive on 10/10, 1927, and that death occurred, on the date stated above, at 12.20 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis, & Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Asthma & Heart Failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Delmar

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Thos. A. Ratliff, M. D.

. 19 (Address) 1623 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Patricks. Date of Burial Oct. 12. 1927.

20 UNDERTAKER H. J. Sadowski. ADDRESS 705 S. Ann St

very important. See instructions on back of certificates.

Exact statement of OCCUPATION is

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26360

CERTIFICATE OF DEATH

10-041 Curtis Bay

D 26360

1-PLACE OF DEATH (Coast Guard.)

REGISTERED NO.

City of BALTIMORE: (No. Pennington Ave St., 25-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah R Porter

(a) RESIDENCE NO. Pennington Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas D Porter

6 DATE OF BIRTH (month, day, and year): June 9 1861

7 AGE: Years 66 Months 4 Days 1 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: at Home

9 BIRTHPLACE (city or town) (State or country): Mattotty A.A.Co Md

PARENTS

10 NAME OF FATHER: Allen Warfield

11 BIRTHPLACE OF FATHER (City or town) (State or country): A.A.Co. Md.

12 MAIDEN NAME OF MOTHER: Annie R Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A.A.Co Md

14 Informant (Address): Mrs Patience M Collison Shipley a A Co Md

15 Filed ....., 19 .....

Registrar

ACS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 9th, 19 27, to Oct 10th, 19 27, that I last saw h 2d alive on Oct 10th 19 27, and that death occurred, on the date stated above, at 11 35 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 10 days.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phy Exam.

(Signed) John Alexander, M. D.

, 19 (Address) Glen Bernie Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — Date of Burial: Oct 12 1927

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26361

CERTIFICATE OF DEATH

14-002

E 26361

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No.) St., 4 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank W. Horchler (Newark Ohio)

(a) RESIDENCE NO. 377 W. Church St St. Ward

(Usual place of abode) Newark, Ohio

Length of residence in city or town where death occurred yrs. mos. about 20 days ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Belle Horchler

6 DATE OF BIRTH (month, day, and year): ~~Unknown~~ April 7 1883

7 AGE: Years 44 Months 6 Days 3 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer B & O. R.R.

9 BIRTHPLACE (city or town) ~~Unknown~~ Newburg

(State or country) W. Va

PARENTS

10 NAME OF FATHER ~~Unknown~~ George H Horchler

11 BIRTHPLACE OF FATHER (City or town) ~~Unknown~~

(State or country) Newburg W. Va.

12 MAIDEN NAME OF MOTHER Mary E Conn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Newburg W Va

14 Informant Francis B Horchler (Wife)

(Address) 377 W. Church St Newark Ohio

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct. 10, 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-22, 1927, to 10-10, 1927, that I last saw h~~er~~ alive on 10-9-, 1927, and that death occurred, on the date stated above, at 4-30 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy of brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H. Lafell, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newark Ohio — Date of Burial: Oct 11 1927

20 UNDERTAKER: John F Denny — ADDRESS: 745 Logan St

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26362

CERTIFICATE OF DEATH

100-001

E 26362

REGISTERED NO. 21-29

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F McCann

(a) RESIDENCE NO. 1211 W. Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 65 Years Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Orderly

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Missouri

(State or country)

PARENTS

10 NAME OF FATHER James F McCann

11 BIRTHPLACE OF FATHER (City or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Lucinda

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant

(Address)

15 Filed ....., 19 .....

Registrar

178 RPA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 12-10-26, 19..., to Oct 8, 1927

that I last saw him alive on Oct 8, 1927

and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Generalized Osteoarcosis, Suppurative Polyarthritis, Venous ulcers

(duration) ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Luetic Aneurism

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms & Findings

(Signed) ..... M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health.

OCT 11 1927

Keep this certificate in plain sight, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26363

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26363

CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST., 8-16 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ehrhardt

(a) RESIDENCE NO. 2210 E. North Ave. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 7-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Arthur Geo. Ehrhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Esther E. Smoot.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant
(Address)

15 Filed ____, 19 1287 ARN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 19 27, to Oct 27, 19 27,
that I last saw him alive on Oct 27, 19 27,
and that death occurred, on the date stated above, at 1:15 PM.
The CAUSE OF DEATH* was as follows:

Premature birth. following Placenta Praevia —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Asphyxia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical.

(Signed) H L Fahney, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	Oct 10 1927
20 UNDERTAKER	ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

E 26364

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 26364

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 26-37 Ward)

2-FULL NAME Mary Kobal

(a) RESIDENCE NO. 5th - 33rd (Holabird) St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9/27

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Chas Kobal

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Stinech

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Charles Kobal

(Address)

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 27 19??

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Coltes M. D.

(Coroner)

19 (Address) 10-11-27 SCB E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Oct 12 1927

20 UNDERTAKER Chas M Weber ADDRESS 1803 Bank St

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec—12-23-21—E.B.R.S.—400 Eks.

E 26365

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26365

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1618 N. Wolfe St., 8-17 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard John D. Johannes

(a) Residence No. 1618 N. Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Katherine E. Johannes

6-DATE OF BIRTH (month, day and year) Aug. 31st 1856

7-AGE. 71 yrs. 1 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Spreader

(b) General nature of industry, business, or establishment in which employed (or employer) Mfg. Clothing

(c) Name of employer Abbed J. Weare

9-BIRTHPLACE (city or town) Unknown (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Unknown (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country), Unknown

14- (Informant) Dr. Norton

(Address) Belair Rd. & Hamilton Ave.

15-

Filed 19?

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 10th 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 19 27 to Oct 10 19 27

that I last saw h alive on Oct 10th 19 27

and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

Heart, acute dilatation

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Congestion Lungs

(Duration) yrs. mos. 1 day

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. L. Davis M. D.

19 (Address) 2108 Bank Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Eastwood Cemetery	Oct 12th 1927
20-UNDERTAKER.	ADDRESS
Fredk. Loatman Sons	Fulton

INSTRUCTIONS ON BACK OF CERTIFICATES.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26366

CERTIFICATE OF DEATH.

7-185

E 26366

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 9-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Petterson

(a) RESIDENCE NO. 112 Fuller Ave (Overlea) St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank Petterson

6 DATE OF BIRTH (month, day, and year) Mar 27/1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Sweden

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Sweden

14 Informant Mrs. John Hoskin (daughter)

(Address) 1724 N. Washington Ave

15 Filed..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10/27 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Neck of Femur

Accidently fel down stairs

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

(Signed) (Coroner) M. D.

10/11-27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial Oct. 13 1927

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS 1710 Fleet St.

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 26367
1-PLACE OF DEATH

CERTIFICATE OF DEATH. 100-001

E 26367

REGISTERED NO. 11-27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 312 W. Hoffman St., Ward)

2-FULL NAME Warner A. Rusk

(a) RESIDENCE NO. 312 W. Hoffman St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1907

7 AGE: Years 20 Months Days If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: waiter

(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

(c) Name of employer: Arabia Club

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Jacob Rusk

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Janie Woodson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va.

14 Informant: Jacob Rusk

(Address): 312 W. Hoffman St.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Kennedy M. D.
(Coroner)

1927 (Address) 257 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: Oct 13 1927

20 UNDERTAKER: Jos. J. H. Rochester — ADDRESS: 1413 Jefferson St.

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

2 57406 E 26368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

V E 26368

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. HOPKINS HOSPITAL ST., 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME APOLANARI. SIWIK

(a) RESIDENCE NO. 816 S. Bond ST. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE: Years 58; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER FRANK SIWIK

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Nitsa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Uncle (Address) HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar K.H.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct-10, 1927, to Oct-11, 1927, that I last saw him alive on Oct-11, 1927, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Emphysema, 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home (Balto)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Warfield M. Firor, M. D.

, 19 (Address) 2400

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem

DATE OF BURIAL: 10 14 1927

20 UNDERTAKER: J. W. Ozmun & Son

ADDRESS: 1930 Eastern Av

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26369

CERTIFICATE OF DEATH.

49 E 26369

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 W. North ave St.; 13-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis B. Wright

(Residence in Baltimore: No. 1318 W. North ave St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 26, 1871.
(Month) (Day) (Year)

7-AGE. 36 yrs. 2 mos. 14 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) ... United R.R.

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Edwin Wright

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Elizabeth Foster

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Wright

(Address) 1318 W. North ave

15-

Filed ..., 191... R. H. ...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 10, 1927.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19 1927, to Oct 10 1927, that I saw him alive on Oct 9 1927, and that death occurred, on the date stated above, at 8.00 a.m.

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma of Brain

(Primary site Supra Scapular Region)

Onset ... (Duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY ...
(Secondary)

... (Duration) ... yrs. ... mos. ... ds.

(Signed) Hubert E. Knapp M. D.

Oct. 11, 1927. (Address) 1716 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Johns-Westminster Md. DATE OF BURIAL, Oct. 14, 1927.

20-UNDERTAKER Richard F. Curley ADDRESS 2062 North Av.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26370

CERTIFICATE OF DEATH.

113 E 26370

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2020 Brunt ST., 14-20 WARD)

REGISTERED NO. ...

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Hudson

(a) RESIDENCE NO. 2020 Brunt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11-1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...m...

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md.

PARENTS

10 NAME OF FATHER John Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Sophia Words

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Hudson (Address) 2020 Brunt St

15 Filed ..., 19... R.M.L. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11 1927

17 I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 19..., that I last saw h— alive on ... 19..., and that death occurred, on the date stated above, at 7-20 A.m.

The CAUSE OF DEATH* was as follows:

a. Contusion

+ Malnutrition

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Henry Eustis, M. D.

10/14, 1927 (Address) 2129 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 12 1927
20 UNDERTAKER	ADDRESS
Henry Easton	916 Ea

Read carefully important—See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26371

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26371

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1241 Mt Royal Ave ST., 11-20 WARD)

2-FULL NAME Ruth Dowson

(a) RESIDENCE NO. 1241 Mt Royal Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James F. Dowson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Louisa Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Miss Kate M. Dowson
(Address) 1241 Mt Royal Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15th, 1922, to Oct 11th, 1927, that I last saw h[illegible] alive on Oct 10th, 1927, and that death occurred, on the date stated above, at 6:35 a m

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
Endocarditis & Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) J. B. Hutchinson, M. D.

10/11, 1927 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Oct 13 1927

20 UNDERTAKER Wm J Tinbergen's — ADDRESS Balto Md

OCT 12 1927 [illegible] Registrar

Spec.—12-9-25—A Co.—200 Bks.

E 26372

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90

E 26372

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1514 W Franklin St.. 19-27 Ward)

2-FULL NAME Jos. Watson

(a) RESIDENCE NO. 1514 W Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Wid.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 75 | Months: | Days: | IF LESS than 1 day ....hrs. or ....min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 0
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): unknown

12 MAIDEN NAME OF MOTHER: unk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): unknown

14 Informant: Harry Watson
(Address): 106 N Arlington

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Oct 10 27

17 I HEREBY CERTIFY, That I attended deceased from June 27, 19 27, to Oct 10, 19 27, that I last saw h.. alive on Oct 7, 19 27, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:
Organic disease of Heart
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulm Oedema
(duration) yrs. mos. V ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.
Oct 10, 19 27 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 26373

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 26373

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 303 N. Pulaski ST., 20 WARD)

2-FULL NAME Mary E Krentzer

(a) RESIDENCE NO. 303 N Pulaski ST., 20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm H. Krentzer

6 DATE OF BIRTH (month, day, and year): June 9 1874

7 AGE — Years: 53 — Months: 4 — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: W. H. Krentzer

(Address): 303 N. Pulaski St

15 Filed , 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 19 27

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19 27. to Oct 10. 19 27.

that I last saw h alive on Oct 10. 19 27.

and that death occurred, on the date stated above, at 2.30 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Yes

(Signed) Walter E Cushman M. D.

10/4. 1927 (Address) 2002 N. Leavitt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London P.K.

DATE OF BURIAL: Oct 13th 1927

20 UNDERTAKER: A. Lewis Schwab

ADDRESS: 2104 Fried Av

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26374

CERTIFICATE OF DEATH.

E 26374
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel E. Kennedy

(a) RESIDENCE NO. 548 S. Bentalou St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augusta Kennedy

6 DATE OF BIRTH (month, day, and year): February 13 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65 yrs.	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Weigher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Mount Clare Stock Yards

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Kennedy

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland

14 Informant: Mrs. Augusta Kennedy

(Address): 548 S. Bentalou St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 9, 1927

I HEREBY CERTIFY, That I attended deceased from October 4, 1927, to October 9, 1927, that I last saw him alive on October 9, 1927, and that death occurred, on the date stated above, at 11.25 p. m.

The CAUSE OF DEATH* was as follows:

Accidental — Fractures of Left Scapula of Seventh and Eighth Ribs - Left side - of Upper End of Right Tibia — (T= fracture)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) .....yrs. .....mos. 3 ds.

Where was disease contracted if not at place of death? At Clare Mount Stock Yards

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical — X ray

(Signed) Wm. J. Knapp, M. D.

10-9, 1927. (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial 10/12 19 27

20 UNDERTAKER: Robert Cook — ADDRESS 1003 W. Baltimore St

Be sure that all items, so far as they are properly classified, are very important. See instructions on back of certificates.

Oct 11 1927

Spec.—1-12-23—M&T—500 Bks.

E 26375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26375

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 W Saratoga ST., 11-35 WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry G P Thomas

(a) RESIDENCE No. 316 W Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelie Thomas

6 DATE OF BIRTH (month, day, and year) Sept 26 47

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Phillip Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Kramm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelie Thomas (Address) 316 W Saratoga St.

15 Filed ... 19 RMM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 6 1924 to Oct 10 1927 that I last saw h[illegible] alive on Oct 10 1927 and that death occurred, on the date stated above, at 4-30 P m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical Exam

(Signed) David Fellman M. D.

19 (Address) 1215 345 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 12 1927
20 UNDERTAKER	ADDRESS
W M Boulton	223 N Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26376
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

113

E 26376
REGISTERED NO.

CITY OF BALTIMORE: (No. 3810 Bank ST., 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W Stork

(a) RESIDENCE NO. 3810 Bank ST., 21 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 5 mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19 · 27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	20 21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Servant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Stork

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Frank Stork
(Address) 3810 Bank St

15 Filed . 19 RUJ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 10 1927

17 I HEREBY CERTIFY, That I attended deceased from October 9, 1927, to October 10, 1927, that I last saw him alive on October 10, 1927 and that death occurred, on the date stated above, at 6-55 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Indigestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Watching at the Bedside
(Signed) [illegible], M. D.
(Address) 1521 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Oak Lawn Cem Oct 12 1927

20 UNDERTAKER — ADDRESS
Stephen J Stalbrook 1000 N Fremont

IMPORTANT is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 26377

CERTIFICATE OF DEATH.

113 E 26377

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1401 Lowman St. St., 24-35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Goddard.

(a) RESIDENCE NO. 1401 Lowman St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 7 mos. 16 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) February 25, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	0	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Daniel K. Goddard.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Illinois.

12 MAIDEN NAME OF MOTHER Annie Sauers.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Annie Goddard. (mother)

(Address) 1401 Lowman St.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt M. D.

(Coroner)

10/11 19 27 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs..... mos..... ds. In the State.....yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Olivet Hill	10/13 1927
20 UNDERTAKER J J Fahey Sons	ADDRESS 13 W. Eight St

Be sure that all items are properly answered in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26378

CERTIFICATE OF DEATH

E 26378

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Providence Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Murphy

(a) RESIDENCE NO. Middle River Park St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ~~7~~ yrs. 1 mos. 5 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 22 1927

7 AGE: Years 7 Months Days 18 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Russell Murphy

11 BIRTHPLACE OF FATHER (City or town)

(State or country) West Va.

12 MAIDEN NAME OF MOTHER Cecelia Purnell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Cecelia Murphy

(Address) Boyce Halethorpe

15 Filed . 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5, 19 27, to Oct. 10, 19 27

that I last saw h alive on Oct. 10, 19 27

and that death occurred, on the date stated above, at 6 59 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) John W. Gaines M. D.

. 19 (Address) Providence Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — Date of Burial: Oct. 12, 1927

20 UNDERTAKER: Mrs. P. A. Elliott — ADDRESS: 1725 Rowland Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26379

CERTIFICATE OF DEATH.

66

E 26379

REGISTERED No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2706 Reese St St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Bland

(a) RESIDENCE NO. 2706 Reese St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15/1901

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	26	1	27 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pittsburg, Pa.

PARENTS

10 NAME OF FATHER John Bland

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Mcale Price

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant Emma Bland (sister)

(Address) 2706 Reese St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Alcoholism

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) [signature] M. D.
(Coroner)

19 (Address) 10/11/27 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial Oct. 12 1927

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Ashland Ave

* Be sure that the cause of death is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26380

CERTIFICATE OF DEATH.

REGISTERED NO. E 26380

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp or nearest St., 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt Thomas

(a) RESIDENCE NO. 2314 Hunter St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Sngl

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Unknown 1881

7 AGE — Years: 46 — Months: (Estimated) — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Fred. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Laura Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Fred Thomas (Address): 2314 Hunter

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation
Sudden Pulmonary Edema

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Oct 8 (Signed) ..... M. D.
(Coroner)
, 19 27 (Address) 1659 Bruce

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Oct 12 27 — Date of Burial

20 UNDERTAKER — ADDRESS: Mrs. D. A. Elliott Woodland Ave

IF DEATH IN PERIODS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26381 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26381

CERTIFICATE OF DEATH. 159-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Gorsuch Ave ST., 9-46 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Smith

(a) RESIDENCE NO. 720 Gorsuch Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year): 10-10 '27

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: George O Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Cary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Smith
(Address): 720 Gorsuch

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-12 1927

17

I HEREBY CERTIFY, That I attended deceased from 10-10 1927 to 10-12 1927

that I last saw h alive on 10-12 1927

and that death occurred on the date stated above, at 1 h. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Malformation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Findings

(Signed) ..... M. D.

19 ..... (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Oct 12th 1927

20 UNDERTAKER: Leo G. Cook

ADDRESS: 1723 N. Patterson Pk Ave

Items in this section are very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 26382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 188-003

E 26382
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John P. Cosgrove

(a) RESIDENCE NO. 2639 Eastern Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catherine Cosgrove

6 DATE OF BIRTH (month, day, and year) Oct 16/1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer 40
(b) General nature of industry, business, or establishment in which employed (or employer) Balto., City
(c) Name of employer Fire Dept.

PARENTS

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

10 NAME OF FATHER Thos. M. Cosgrove

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary V. Wilson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Catherine Cosgrove
(Address) 2639 Eastern Ave

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock- Hemorrhage crushedchest
Accidebtly run over by automobile
at Luzerne & monument St
(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
(duration) .....yrs. .....mos. .....ds.

(Signed) J. D. Kolen M. D.
(Coroner)
10-12, 1927 (Address) 508 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: Oct. 13 1927

20 UNDERTAKER: John A. Maan — ADDRESS: 3000 E. Balto.

OCT 12 1927

If DEATH is not properly classified. Exact statement of CAUSE is very important. See instructions on back of certificate. Use pen and ink, so that it may be preserved in permanent form. Fill in all blanks. Do not abbreviate. Write plainly. Do not use ditto marks. Do not leave any blanks. If OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26383 E 26383

CERTIFICATE OF DEATH.

25-17

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 Peral ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cierpierski.

(a) RESIDENCE NO. 23 Peral ST., 23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Katarzena Cierpierski

6 DATE OF BIRTH (month, day, and year) Oct 7 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	33		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Burner

(b) General nature of industry, business, or establishment in which employed (or employer) B.T.C. & R.R.

(c) Name of employer B.T.C. & R.R.

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Cierpierski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Przyulska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Cierpierski (Address) 923 Peral St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1927

17

I HEREBY CERTIFY, That I attended deceased from July 23, 1927, to Oct. 10, 1927, that I last saw him alive on Oct 9, 1927, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis.

(duration) yrs. 3 mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

Oct 11, 1927 (Address) 846. Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross DATE OF BURIAL Oct 13 - 1927

20 UNDERTAKER J W Ozuzewski ADDRESS 1930 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

205-917

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26384

E 26384

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura A - Best

(a) RESIDENCE No. 50-W. 45th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced, (write the word): ~~Widowed~~ Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of:

6 DATE OF BIRTH (month, day, and year): 8-54

7 AGE: Years 73 | Months 2 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia —

PARENTS

10 NAME OF FATHER John Beland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Amanda Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia —

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11/27 1927

17 I HEREBY CERTIFY, That I attended deceased from August 16, 1927, to Oct-11, 1927, that I last saw her alive on Oct-11, 1927, and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) W. Lindsay Hiller, M. D.

10/11 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York N.Y. DATE OF BURIAL: Oct 14 1927

20 UNDERTAKER: John C. Mitchell & Sons ADDRESS: 1700 Eutaw Place

FOR A VERY important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

Catherine Harrington

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26385

CERTIFICATE OF DEATH

45 E 26385

1-PLACE OF DEATH Jenkins Memorial Hospital

REGISTERED NO.

City of BALTIMORE: (No. ____ St., 14 Ward) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine Harrington

(a) RESIDENCE NO. 1501 Druid Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S. If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robt. Harrington

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years 51 Months Days

IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (City or town)

(State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) " "

14 Informant Edward Kramer

(Address) 1501 Druid Hill Ave

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 4th, 1927, to Oct 12, 1927, that I last saw her alive on Oct 12, 1927, and that death occurred, on the date stated above, at 1.40 a.m.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma of Omentum

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) General Metastasis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis J. Murray M. D.

, 19 (Address) St Agnes' Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial 10/15 1927

20 UNDERTAKER: Henry W Meadows Son — ADDRESS 803 N. Salina St.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26386

CERTIFICATE OF DEATH.

11-23 ✓ E 26386

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2728 Riggs Ave., ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otelea C. Cassidy

(a) RESIDENCE NO. 2728 Riggs Ave., ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas P. Cassidy

6 DATE OF BIRTH (month, day, and year) March 31, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	32	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0-31

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Walter Ehrlich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha L. Dauge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Thomas P. Cassidy 2728 Riggs Avenue

15 Filed OCT 13 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11, 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1927 to Oct.10, 1927, that I last saw her alive on Oct.10, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis 1Yr. ?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw Vennard M. D.

10/12/27 (Address) 24 W Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	10/14 1927

20 UNDERTAKER George J Ruth ADDRESS 1755 Harford Av

Please write very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 26387

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26387

CERTIFICATE OF DEATH.

129 v

REGISTERED No. 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Southern Hospital Annex

CITY OF BALTIMORE: No. 2520 Wrenmount Ave ST., WARD

2-FULL NAME Ida E. A. Russell

(a) RESIDENCE No. 2520 Wrenmount Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed or divorced (HUSBAND of (or) WIFE of) Charles Russell

6 DATE OF BIRTH (month, day, and year) April 7-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Michael Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Albert Hartmeyer
(Address) 1810 E. Pratt St

15 Filed OCT 13 1927, 19 HAMILTON JONES, M. D. Registrar
RPK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 6, 1927, to Oct 11, 1927, that I last saw h[illegible] alive on Oct 11, 1927, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Urine

(Signed) W. Bryan, M. D.

, 19 (Address) 1529 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 14 1927
20 UNDERTAKER	ADDRESS
George W. Zinkler	1737 E. Eager St.

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 V

E 26388 — REGISTERED NO. E 26388

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. 11-24 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Fisher

(a) RESIDENCE NO. 925 Morris St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Saml J Ballard

11 BIRTHPLACE OF FATHER (City or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Howe

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Edward Ballard

(Address) 543 N Bradford St

15 Filed ..... 19 ..... Registrar

OCT 12 1927 C. HAMBLETON, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10 - 10 - 27

17 I HEREBY CERTIFY, That I attended deceased from 10-10, 1927, to 10-10, 1927

that I last saw h alive on 10-10, 1927,

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, Hypertension

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

10/11/1927 (Signed) John Roberts Phillips M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — Date of Burial OCT 13 1927 19

20 UNDERTAKER Samuel T Handley — ADDRESS 578 N Bradford

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26389

CERTIFICATE OF DEATH.

179

E 26389
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Carlton Hospital St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosalie Dorsey

(a) RESIDENCE NO. 1028 N. Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 4 1922

7 AGE: Years 4 Months 11 Days 5

IF LESS than 1 day.....hrs. or.....min. 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER Lemuel Dorsey

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie Brown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md.

14 Informant Carrie Dorsey

(Address) Baltimore Co.

15 Filed....., 19.... Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd degree burns of body

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cloth Caught fire while playing with matches

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Kenney M. D.

(Coroner)

, 19 27 (Address) 25 N Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial OCT 13 1927 19

20 UNDERTAKER Chas. L. T. Hemsley ADDRESS 578 N. Eutaw St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 26390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001

E 26390

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Tress

(a) RESIDENCE NO. 1034 N. Washington St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Tress

6 DATE OF BIRTH (month, day, and year) March 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61 62	7		

8 OCCUPATION OF DECEASED Brick Layer / none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER John Tress

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER Christine Knox

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Arthur Tress

(Address) 1925 E. Chase St.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Oct 11/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia-Gangrenous bowel etc
Strangulated Inguinal Hernia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Carl Cates, M. D.
(Coroner)

10-12 1927 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Oak Lawn Cemetery Oct 14 1927

20 UNDERTAKER — ADDRESS

Henry Lutz N. Broadway

OF DEATH is plain (ems, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26391 — REGISTERED NO. 45 E 26391

1-PLACE OF DEATH St. Joseph's Hospital

City of BALTIMORE: (No. ..... Caton St., 6-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Everett Smith.

(a) RESIDENCE NO. 1515 E. Preston St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 0 mos. 1 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Oct 11 1865

7 AGE — Years: 62 — Months: 0 — Days: 1 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): Nurse

(c) Name of employer: Nurse

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER W. H. Arthur

11 BIRTHPLACE OF FATHER (City or town) Charlestown (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edward H. Arthur (Address) 1515 E Preston

15 Filed ..... 19 ..... Registrar RLR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to Oct 12, 1927, that I last saw h.. alive on Oct 12, 1927, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid

Causing Intestinal Obstruction

Exploratory — Primary Tumor

(duration) ..... yrs. ..... mos. Weeks ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 20 27

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Surgical

(Signed) ..... M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — Date of Burial Oct 14 19 27

20 UNDERTAKER: W. H. Anderson — ADDRESS ..... Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26392

CERTIFICATE OF DEATH.

90

E 26392

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 310 Fair Oaks av. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharina Hickes

(a) RESIDENCE NO. 1705 Hanover St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. Hickes

6 DATE OF BIRTH (month, day, and year): Oct. 12 - 1865

7 AGE: Years 61 | Months 11 | Days 29 | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Pfister

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Mr. Heil

(Address): 310 Fair Oaks av

15 Filed ..... 19.....

CHAMPION JONES M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11, 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1927, to Oct 11, 1927, that I last saw her alive on Oct 10, 1927, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocaridid

Insufficiency (duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frd. L. Zimmerman M. D.

10/11, 1927 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — Date of Burial: 10/13 1927

20 UNDERTAKER: I. Fenwick Mc Colly — ADDRESS: 130 E. Fort

OCT 13 1927

Be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

No. Kensington Avenue
29 - Edmondson St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26393

CERTIFICATE OF DEATH.

89

E 26393

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Gilman Apts Edmondson St WARD)

REGISTERED NO. 12-356

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Foris Fallon

(a) RESIDENCE No. Gilman Apts Edmondson St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of George A

6 DATE OF BIRTH (month, day, and year) Jan 7 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Peter Foris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Julia Coe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn

14 Informant Eleanor Fallon

(Address) Gilman Apts Edmondson

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 10 , 1927 , to Oct 12 , 1927 ,

that I last saw her alive on Oct 11 , 1927 ,

and that death occurred, on the date stated above, at about 6.30 Am.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. about mos 45 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

not known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? The usual ones.

(Signed) Marie L. Lingane M. D.

, 19 (Address) 2499 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edmondson Ave - Oct 13 1927

DATE OF BURIAL

20 UNDERTAKER H. M. Cox

ADDRESS 532 E Pratt

FROM A VERY important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

152 E 26394

E 26394

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. 33d & Calvert St., 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret M. Wiseman

(a) RESIDENCE NO. 2636 E. Hoffman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Robert Wiseman

6 DATE OF BIRTH (month, day, and year) Jan 22, 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	30	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Mr. G. Scheere

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Holt

13 BIRTHPLACE OF MOTHER (city or town) America

(State or country)

14 Informant Robert J. Wiseman

(Address) 2636 E Hoffman

15 Filed ..... 19 ..... Registrar

OCT 13 1927 C. HAMMOND, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1927 to Oct 11, 1927 that I last saw her alive on Oct 11, 1927 and that death occurred, on the date stated above, at 1:20 P m.

The CAUSE OF DEATH* was as follows:

Carbuncle on face

(duration) ..... yrs. ..... mos. 8 da.

CONTRIBUTORY (Secondary) Septicemia

(duration) ..... yrs. ..... mos. 3 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. A. Hammond, M. D.

. 19 (Address) Union Memorial Hospital 33d & Calvert Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Parkwood Cemetery	10/14 1927
20 UNDERTAKER Wm Cook	ADDRESS Sole Nath Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26395

CERTIFICATE OF DEATH.

90 E 26395

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4803 Wilson Ave ST. 7-48 (WARD)

2-FULL NAME Frances V. Broome

(a) RESIDENCE NO. 4803 Wilson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/+ yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Broome

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Paulina Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant F. M. Slack
(Address) 4803 Wilson Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11th 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 11th, 1927,

that I last saw h[illegible] alive on Oct 11th, 1927,

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. S. Howe, M. D.

11/11, 19 (Address) 720 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Oct 13 1927
20 UNDERTAKER Wm Cook	ADDRESS 502 E Mad

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26396

1-PLACE OF DEATH

REGISTERED E 26396

City of BALTIMORE: (No. 4306 Lauretta Ave St., 27-44 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma E. Schuster

(a) RESIDENCE NO. 4306 Lauretta Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles C. Schuster

6 DATE OF BIRTH (month, day, and year) Mar 25/1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Peter Bancus

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Annie E. Peterson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Charles C. Schuster

(Address) 4306 Lauretta Ave

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension-probably arteriosclerotic (duration) yrs. mos. ds.

(Signed) J. H. Bullen M. D.

(Coroner)

18 (Address) 508 E. North Ave 10-12/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sarkwood Cemetery Date of Burial Oct 14 19

20 UNDERTAKER Urciano Cook ADDRESS 502 E North Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 14 1927 C. HARRISON JONES M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26397

CERTIFICATE OF DEATH.

49

REGISTERED NO. E 26397

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Woodley St., ST., 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ray Grollman

(a) RESIDENCE No. 1011 Woodley ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellis Grollman

6 DATE OF BIRTH (month, day, and year): ------1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Boris Kristel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Yetta -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Ellis Grollman (Husband)
(Address): 1011 Woodley St.

15 Filed ____, 19__ Per ____, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-11 - 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to Oct 11, 1927, that I last saw her alive on Oct 10, 1927, and that death occurred, on the date stated above, at 4.50 A. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma - left kidney
Metastasis in dorsal + lumbar spine + pelvic bones. (duration) 2½ yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sections from kidney.

(Signed) Ray Harry Lewis D. and Easty, M. D.

10-11, 1927 (Address) 37 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Wash. Road — DATE OF BURIAL: 10-13-1927

20 UNDERTAKER: Jack Lewis, 1439 E. Balt — ADDRESS

FOR is very important. See instructions on back of certificates.

OCT 13 1927 C. HAMILTON JOHNS, M.D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26398

CERTIFICATE OF DEATH.

41 ✓

E 26398

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Gaczkowski

(a) RESIDENCE NO. 242 S. Ann St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Gaczkowski

6 DATE OF BIRTH (month, day, and year) Sept 21/1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer Gibbs Preserving Co

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER John Gaczkowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Osowski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Wife

(Address) 2421 Aisquith St

15 Filed 19 Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia-Accidental contusion of small boil on left elbow about 10 days previous

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Haller (Coroner) M. D.

19 (Address) 10-12-27 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem Date of Burial Oct 15 1927

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26399

CERTIFICATE OF DEATH

129 E 26399

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1644 E. Eager St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael H. Silbersack

(a) RESIDENCE NO. 1644 E Eager St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Barbara M. Silbersack

6 DATE OF BIRTH (month, day, and year) May 4 1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	62	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Silbersack

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs. Barbara M. Silbersack (Address) 1644 E Eager St

15 Filed OCT 10 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11 19 27

17 I HEREBY CERTIFY, That I attended deceased from July, 1927, to October 10, 1927, that I last saw him alive on October 10, 1927, and that death occurred, on the date stated above, at 11.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis J. Ayd M. D.

Oct 11, 1927 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Date of Burial Oct 14 1927

20 UNDERTAKER Henry Koeck Son ADDRESS 1301 E Eager St

OCT 10 1927 R. HARRISON JONES, M.D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26400

CERTIFICATE OF DEATH

161-001 E 26400

REGISTERED NO.

1-PLACE OF DEATH

Brooklyn

City of BALTIMORE: (No. 217 Potomac Ave. St., 25-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Major C. & Anna G. Burchett

(a) RESIDENCE NO. 217 Potomac Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day 23 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn, Md.
(State or country)

PARENTS

10 NAME OF FATHER Major C. Burchett

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Wilkes-Barre, N. C.

12 MAIDEN NAME OF MOTHER Anna G. Houghtling

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Mrs. Anna G. Burchett
(Address) 217 Potomac Ave. Brooklyn

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1927

17 I HEREBY CERTIFY, That I attended ~~deceased~~ from Oct 10th, 1927, to Oct 11th, 1927, that I last saw ~~he~~ alive on Oct 11th, 1927, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. 23 hours ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Thomas Leidich M. D.

10/13 1927 (Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial Oct 13 1927

20 UNDERTAKER John F. Denny ADDRESS 715 Lafayette

N. B.—WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 13 1927 HAMPDEN-WOODBERRY

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26401 E 26401

CERTIFICATE OF DEATH

129

1-PLACE OF DEATH REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rhea Reisenweber

(a) RESIDENCE NO. 2028 E. 31st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1890

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
37	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Meinhardt

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna League

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs Rhea Reisenweber
(Address) 2028 E. 31st St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1927, to Oct 12, 1927

that I last saw h alive on Oct 12, 1927

and that death occurred, on the date stated above, at 7 10 A m.

The CAUSE OF DEATH* was as follows:

chronic nephritis & hypertension plus acute Nephritis.

(acute) → (duration) yrs. 1 mos 12 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. 1 mos 12 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Anuria & uremia

(Signed) Palmer V. C. Williams, M. D.

Oct 12, 1927 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem. — Date of Burial Oct 15 1927

20 UNDERTAKER Geo. Hund — ADDRESS 2016 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26402

CERTIFICATE OF DEATH

101-001

E 26402

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2619 E. Baltimore St. Ward) 6-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Klotzsch

(a) RESIDENCE NO. 2619 E. Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret E. Klotzsch

6 DATE OF BIRTH (month, day, and year): Aug 3 1849

7 AGE: Years 80 Months 2 Days 8 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Lager Mfg

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Christopher Klotzsch

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Wentzel

13 BIRTHPLACE OF MOTHER (City or town)

(State or country): Germany

14 Informant: Mrs Wm Schwartz

(Address) 2609 E Baltimore St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 1927

17 I HEREBY CERTIFY, That I attended /deceased from Oct 3, 1927 to Oct 11, 1927, that I last saw h[illegible] alive on Oct 11, 1927, and that death occurred, on the date stated above, at 6 55 PM.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos ds.

18 Where was disease contracted

if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Chas F. Block, M. D.

Oct 13 1927 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Park — Date of Burial: Oct 15 1927

20 UNDERTAKER: Phil Herrid — ADDRESS 2016 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 15 1927 HAMPDEN BRANCH

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26403

CERTIFICATE OF DEATH

91-602 E 26403

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2100 E. Biddle St., E Ward) 6-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Smith Jr.

(a) RESIDENCE NO. 2100 E Biddle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word).
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Smith

6 DATE OF BIRTH (month, day, and year) June 3/1851

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	76	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor & Builder

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Fixture Mfg

(c) Name of employer Himself

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER — Smith

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mat Mann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Mary Smith
(Address) 2100 E Biddle St

15 Filed Oct 13 19 27 CHAMPION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1927, to Oct 10, 1927, that I last saw h.. alive on Oct 10, 1927, and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Aortic Sclerosis

(duration) — yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

Oct 13 19 27 (Signed) G. C. Gladden, M. D.
(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. — Date of Burial Oct 13 19 27

20 UNDERTAKER Chas Young — ADDRESS 226 Lexington

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 26404 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26404

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1519 E Lanvale ST., 8-17 WARD 89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory J Wilson

(a) RESIDENCE NO. 1519 E Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Carrie L Wilson

6 DATE OF BIRTH (month, day, and year) Jan 29th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer) Dixon & Bartlett Shoe Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anne Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Carrie L Wilson

(Address) 1514 E Lanvale St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11th 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 7, 1927, to Oct 11, 1927,

that I last saw him alive on Oct 10, 1927,

and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis & Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W Jamieson, M. D.

, 19 (Address) 1711 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pinewood Cemetery	Oct 14th 1927
20 UNDERTAKER	ADDRESS
Geo C Harman & Sons	1126 N Howard St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

7/4-001 VE 26405

E 26405

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 19-28 Ward)

(If death occurred in a hospital or institution give its NAME instead of street and number.)

2-FULL NAME Aurelia Gross

(a) RESIDENCE NO. 1621 W. Pratt St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3, 1908

7 AGE: Years 19 Months 5 Days 9

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Gross

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie Hayes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto.

14 Informant

(Address) Hospital Record.

15 Filed ..... 19 ..... Registrar

OCT 13 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/12 1927

17

I HEREBY CERTIFY, That I attended deceased from 10/11, 1927, to 10/12, 1927.

that I last saw her alive on 10/12, 1927.

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 10/11/27

Was there an autopsy? Nasal Septum Deviation

What test confirmed diagnosis? Clinical

(Signed) L. A. Turnbull, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western (Cem)

Date of Burial: 10/14 19 27

20 UNDERTAKER: E. L. Roy Stifler

ADDRESS: 259 North -ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 26406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 26406

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 728 N. Fulton Ave. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Owens

(a) RESIDENCE NO. 728 N Fulton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19, 1855

7 AGE	Years	Months	Days
	72	1	22

IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) A. A. Co Md

PARENTS

10 NAME OF FATHER Augustus Drury

11 BIRTHPLACE OF FATHER (City or town)

(State or country) A. A. Co Md

12 MAIDEN NAME OF MOTHER Susan Welch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) A. A. Co. Md

14 Informant Nelson W. Owens

(Address) 728 N Fulton Ave

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Oct 11 -

17 I HEREBY CERTIFY, That I attended deceased from July 11 - 1927 to Oct 11 - 1927

that I last saw h[illegible] alive on Oct 10 - 1927

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver.

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY

(Secondary)

(duration) - yrs. - mos. - ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) M Bowman and Hood, M. D.

11/12. 1927. (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Annapolis Stannbern. Md	Oct 13 1927
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.– 12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26407

CERTIFICATE OF DEATH.

162

REGISTERED NO. E 26407

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE) (No. 2509 East an St. 1-3 Ward)

2-FULL NAME Lapart Nagrotski

(a) RESIDENCE NO. 2509 East an St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12 97

7 AGE — Years: 6 — Months — Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jan Nagrotsky

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country) Poland

12 MAIDEN NAME OF MOTHER Ana Spinek

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Jan Nagrotsky

(Address) 2509 Jordan

15 Filed ..... 19..... Registrar

OCT 15 1927 C. HAMPSON JONES, M. D.

Per Kelly

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 19 27 to Oct 12 19 27, that I last saw h. alive on Oct 12 19 27, and that death occurred, on the date stated above, at 11 5 m.

The CAUSE OF DEATH* was as follows:

Acute Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis?

(Signed) William Ryan M. D.

(Address) 801 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Date of Burial Oct 14 1927

20 UNDERTAKER: J W Bazewski ADDRESS 1750 Fordham Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26408 ✓ E 26408

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1357 N. Stricker ST. 15-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Jones

(a) RESIDENCE NO. 1357 N. Stricker ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND ~~of~~ or WIFE of: Lucius Jones

6 DATE OF BIRTH (month, day, and year): — — 1857

7 AGE: Years 70 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Mary Brown

(Address) 1322 N. Stricker St

15 Filed Oct 12 1927 C. HAMPSON JONES, M. D. Registrar

Per KAUL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11. 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 25 . 1927 . to Oct 11. . 1927 .

that I last saw h~~er~~ alive on " " . 1927 .

and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

10/11, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn — DATE OF BURIAL: Oct 12 1927

20 UNDERTAKER: Sam'l N. Chase & Son — ADDRESS: [illegible]

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 26409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26409

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2816 Ulman Ave ST. 15-58 WARD)

2-FULL NAME Paul Solomon

(a) RESIDENCE. No. 2816 Ulman Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced, (or) WIFE of: Mamie Solomon

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 76 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Isaac Leon Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Leah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Son in Law - Mr. Rosenberg
(Address) 2816 Ulman Ave

15 Filed OCT 13 1927 19 H. HAMILTON JONES, M. D. Registrar
Per RHJ

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct — 1926 to Oct 12 1927
that I last saw her alive on Oct 12 — 1927
and that death occurred, on the date stated above, at 1.30 a. m.
The CAUSE OF DEATH* was as follows: Cardiac Asthenia

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary): Pneu

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H M Bergan M. D.

10/13/27 (Address) 3455 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave — DATE OF BURIAL: 10-14 1927

20 UNDERTAKER: Leo Levin — ADDRESS: 1439 E Baltimore

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Letter in file from Dr Langfitt Dated Oct 27-1927

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26410

CERTIFICATE OF DEATH

90 E 26410

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3021 W Lanvale St., St. 11-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Merchant,

(a) RESIDENCE NO. 3021 W Lanvale St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Mary E. nee (Smith)

6 DATE OF BIRTH (month, day, and year): July 15. ~~1861~~ 1866

7 AGE: ~~61~~ Years 2 Months 25 Days IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Leather Tanner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Norfolk,

(State or country): Va.

PARENTS

10 NAME OF FATHER: Francis H Merchant

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

14 Informant: John P. Merchant,

(Address): 3021 W Lanvale St.

15 Filed ..... 19 ..... Registrar

OCT 13 1927 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927, to Oct 10, 1927,

that I last saw h— alive on Oct 6, 1927,

and that death occurred, on the date stated above, at 7.15 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) ....yrs. 9 mos ....da.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) 1 yrs. ....mos ....da.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) [illegible], M. D.

10/12, 1927 (Address) 21 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — Date of Burial: Oct 14 1927

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1521 W Lanvale St

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26411

REGISTERED NO. E 26411

1-PLACE OF DEATH

City of BALTIMORE: (No. 2307 Fleet St., 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRANK PRZYBYLSKI,

(a) RESIDENCE NO. 2307 Fleet St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S. if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonia Przybylski,

6 DATE OF BIRTH (month, day, and year) September 14-1862.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	65	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day labororer,

(b) General nature of industry, business, or establishment in which employed (or employer) O.W.O

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER Ignatius Przybylski,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Katharine Jagodzynska,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Mrs. Antonia Przybylska,

(Address) 2307 Fleet Street

15 Filed ..... 19 .....

Registrar

OCT 13 1927 C. HAMPSON

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct. I2/I927.

17 I HEREBY CERTIFY, That I attended deceased from Oct. I/27 19 .... to Oct. I2/27. 19 ....

that I last saw him alive on Oct. I2/27. 19 ....

and that death occurred, on the date stated above, at I.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

unknown. (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis.

unknown. (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis? phys. exam.

(Signed) [illegible], M. D.

Oct 13 1927 (Address) 100 N. Linwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Stanislaus.	Oct 15 1927
20 UNDERTAKER M. J. Sadowski.	ADDRESS 702 S. Mon

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26412

CERTIFICATE OF DEATH

E 26412

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 505 N. Carey St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boleman

(a) RESIDENCE NO. 505 N. Carey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/11/27

7 AGE Years Months Days IF LESS than 1 day hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Freddie Boleman

11 BIRTHPLACE OF FATHER (City or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Ariz Brooks

13 BIRTHPLACE OF MOTHER (City or town) Balto Md

(State or country)

14 Informant Ariz Boleman

(Address) 505 N. Carey

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1927, to Oct 11, 1927, that I last saw her alive on Oct 11, 1927, and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ida E. Bell, M. D.

, 19 (Address) 710 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JOHNS HOPKINS HOSPITAL OCT 12 1927

C. HAMPSON JONES, M.D.

Commissioner of Health

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26413

CERTIFICATE OF DEATH.

E 26413

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 148 Louden Ave St. 20-71 Ward)

2-FULL NAME Henry F. Kroeger

(a) RESIDENCE NO. 148 Louden Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 4 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary D. Kroeger

6 DATE OF BIRTH (month, day, and year): March 7th 1859

7 AGE — Years: 68 — Months: 7 — Days: 4 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night Captain City Jail

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Saxo

PARENTS

10 NAME OF FATHER: Henry Kraeger

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Denker

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mary Kraeger

(Address): 148 Louden Ave

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by myself and the autopsy, and/or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. 15 Min mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D. (Coroner)

Oct 13th, 1927 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Pk Cemetery — Date of Burial: Oct 14 19 27

20 UNDERTAKER: J. F. Tubman's Sons — ADDRESS: Balto Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26414

CERTIFICATE OF DEATH.

113E 26414

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. [illegible] St. [illegible] WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Weddington

(a) RESIDENCE No. 702 Harford Ave ST. ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col-	Mar

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-16-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6 Months	5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Weddington

11 BIRTHPLACE OF FATHER (city or town) Balt
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Washington

13 BIRTHPLACE OF MOTHER (city or town) Balt, Md
(State or country)

14 Informant Records JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1927, to Oct-7, 1927, that I last saw her alive on Oct. 7, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute gastro intestinal
indigestion.
Diarrhoea + vomiting

(duration) ..... yrs. ..... mos 21 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Allan Blackman, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19

20 UNDERTAKER .....
ADDRESS .....

THIS is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.
JOHNS HOPKINS HOSPITAL
OCT 13 1927

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20 E 27 26415

CERTIFICATE OF DEATH.

161 E 26415

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 9-10 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brown

(a) RESIDENCE No. 613 N. Dallas ST. ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or ~~Divorced~~ (write the word): Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-1-27

7 AGE: Years ..... Months ..... Days 8 Days ..... If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work \
(b) General nature of industry, business, or establishment in which employed (or employer) \
(c) Name of employer \

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Laine Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Grace Dies

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed ....., 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 19 27, to Oct. 8, 19 27, that I last saw h[illegible] alive on Oct. 5, 19 27 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? YES

What test confirmed diagnosis?

(Signed) Allan Blackman, M. D.

, 19 (Address) The Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

THIS IS very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 26416

HEALTH DEPARTMENT—CITY OF BALTIMORE E 26416

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 3-4 WARD)

2-FULL NAME Ralph Cuccaro

(a) RESIDENCE No. 251 S Eden ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1927

7 AGE — Years — Months — Days — If LESS than 1 day 16 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Vincent Cuccaro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Antonette Ramunto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Office of Hosp. Johns Hopkins Hospital

15 Filed ..., 19 1505 DeBB. Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1927, to Oct. 6, 1927, that I last saw her alive on Oct. 6, 1927, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Lott Mackenzie, M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

OCT 10 1927

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 26417

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26417

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 35 WARD)

2-FULL NAME Baby Levison

(a) RESIDENCE NO. 27 S Exeter ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1927

7 AGE Years ..... Months ..... Days ..... If LESS than 1 day, hrs. ..... or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. U.S.

PARENTS

10 NAME OF FATHER Joe Levison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Bondeia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Johns Hopkins Hospital. (Address) Chas. Whitman M.D.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1927

17

I HEREBY CERTIFY, That I attended deceased from 10-6 .1927. to 10-6 .1927.

that I last saw h[illegible] alive on 10-6 .1927

and that death occurred, on the date stated above, at 3 30 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Whitman M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER C. HAMPSON JONES M. D.

ADDRESS Commissioner Health.

OCT 13 1927

OCT 13 1927

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26418 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26418

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 Ridgely — St., 21-24 WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C Shipley

(a) RESIDENCE NO. 932 Ridgely — ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward C. Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma R. Seymour

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Emma Hampton (Address) 932 Ridgely St

15 Filed ... 1927 ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12, 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 25, 19 27, to Oct 12, 19 27, that I last saw h(e) alive on Oct 12, 19 27, and that death occurred, on the date stated above, at 1-30 m., The CAUSE OF DEATH* was as follows:

Aortic regurgitation

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Ford, M. D.

19 19 — (Address) 1 Franklin Sq

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 15 1927

20 UNDERTAKER H McCurley

ADDRESS 502 Fulton

T. HAMPSON JONES, M. D.

Port

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 26419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126 E 26419

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. #3 N. Calhoun St. 14-16 Ward)

2-FULL NAME Theodore D. Austin

(a) RESIDENCE NO. #3 N. Calhoun St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): December

7 AGE: Years: About 72 Months: — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chair Assembler

(b) General nature of industry, business, or establishment in which employed (or employer): 86

(c) Name of employer: Hayward Bros & Co

9 BIRTHPLACE (city or town): Bacto

(State or country)

PARENTS

10 NAME OF FATHER: Theodore D. Austin

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Sophia Kyle

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Chas E. Austin

(Address) 225 So. First st - Brooklyn

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained at said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos B. Horton M. D.

Oct 13 1927 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. [illegible]

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Oct 14 1927

20 UNDERTAKER: Wilson Cook — ADDRESS: Sole Park

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 26420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 26420

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Hospital for the Women of Md. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Harris.

(a) RESIDENCE NO. 4822 Park Heights Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 7 mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: J. Thomas Harris.

6 DATE OF BIRTH (month, day, and year): March 29, 1865

7 AGE 62 Years 7 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Freedom,

(State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: John Dechabaugh

11 BIRTHPLACE OF FATHER (City or town): ?

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary Fox

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Frederick Co. Md.

14 Informant: J. Thomas Harris,

(Address): 4822 Park Heights Ave.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: October 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1927, to Oct. 12, 1927, that I last saw h[illegible] alive on Oct 12, 1927, and that death occurred, on the date stated above, at 9:25 P. m.

The CAUSE OF DEATH* was as follows:

Thrombophlebitis

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

Myocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted

If not at place of death? 4822 Park Heights Ave.

Did an operation precede death? Yes. Date of Aug. 25, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) F. H. Krock, M. D.

. 19 (Address) Woman Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Freedom Cemetery	Oct 16 1927
20 UNDERTAKER	ADDRESS
Uhlman Corp	501 Park

OCT 13 1927 C. HAMPSON WHITE

Pd. $5.00 No. 21

Should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -7-17-26 -A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26421

E 26421

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 90

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS 2755 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonette Friska or Freska

(a) RESIDENCE NO. 6218 Belmont Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Bohemian widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) unknown 1855

7 AGE 72 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia

(State or country)

PARENTS

10 NAME OF FATHER Alexander

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Antonelli

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bohemia

14 Informant BALTIMORE CITY HOSPITALS

(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 12 1927

17 I HEREBY CERTIFY, That I attended deceased from 10 - 4, 1927 to 10 - 12, 1927

that I last saw her alive on 10 - 12, 1927

and that death occurred, on the date stated above, at 6-55 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chr. myocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted ?

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) C. Hilton Boyd M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial Oct 15 1927

20 UNDERTAKER Frank Brachdal — ADDRESS 1906 Eastern Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26422

CERTIFICATE OF DEATH.

E 26422

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1528 Clarkson ST. 23 WARD 36

REGISTERED NO. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Sanders

(a) RESIDENCE No. 1528 Clarkson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Male~~ ~~Female~~

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Tedach Sanders

6 DATE OF BIRTH (month, day, and year) June 15th 1856

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
71	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Sanders (Address)

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

OCT 13 1927

APH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1926, to Oct 12, 1927, that I last saw h alive on Oct 12, 19..., and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

Oct 12, 1927 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 10/15/1927

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26423

12E 26423

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 4726 Frederick Ave. St. 28-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Daniel Chiswick

(a) RESIDENCE NO. 4726 Frederick Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mary A. Chiswick

6 DATE OF BIRTH (month, day, and year) March 4, 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	77	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist, retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West Indies

(State or country)

PARENTS

10 NAME OF FATHER William Chiswick

11 BIRTHPLACE OF FATHER (City or town) London

(State or country) England

12 MAIDEN NAME OF MOTHER Caroline Gagen

13 BIRTHPLACE OF MOTHER (city or town) London

(State or country) England

14 Informant Mrs. Bertha Stevens

(Address) 4726 Frederick Avenue

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1927, to Oct 12, 1927, that I last saw him alive on Oct 11, 1927, and that death occurred, on the date stated above, at 10.45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

" Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Chas. C. Conrad, M. D.

10/12, 1927. (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: 10/14/27

20 UNDERTAKER: [illegible] — ADDRESS: 1003 W. Baltimore St

OCT 13 1927 C. HAMPSON JONES, D.

Per APH

Be sure to carefully supply ALL items be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26424

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26424

24-901

18-24

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 863-1/2 W. Lombard St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joanna W. Ewing

(a) RESIDENCE NO. 863-1/2 W. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Ewing

6 DATE OF BIRTH (month, day, and year) August 7, 1845

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	82	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Enoch Warfield

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Anne Arundel Co., Md.

12 MAIDEN NAME OF MOTHER ? Hawkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Anne Arundel Co., Md

14 Informant Miss Miriam W. Shaw

(Address) 1813 West Baltimore St

15 Filed 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 20 to Oct 11 19 27,

that I last saw her alive on Oct 10 19 27,

and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope.

about 12 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

7 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) J. Patrick Ewell, M. D.

Oct 12, 1927 (Address) 2945 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial 10/14/27 19

20 UNDERTAKER A. B. Cook

ADDRESS 1003 W. Baltimore St

OCT 13 1927 C. HAMPSON JONES, M.D.

Be sure and be careful in supplying AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

26425 E

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 V E 26425

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. 16-29 St.) Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Orrell

(a) RESIDENCE NO. 1020 Hollins St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3½ mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 - 1924

7 AGE Years: Months: 3½ Days: IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Balt. Md.
(State or country)

PARENTS

10 NAME OF FATHER Vernon Orrell

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine McClain

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Mr Vernon Orrell
(Address) 1020 Hollins St

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 13. 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1927, to Oct 13, 1927, that I last saw him alive on Oct 13 1927, and that death occurred, on the date stated above, at 1.25 a.m.

The CAUSE OF DEATH* was as follows:

Diuteroconvulsio

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically.

(Signed) W. E. A. H. Finkelstein M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: Oct 14 1927

20 UNDERTAKER: John J. Cowan & Son. ADDRESS: 901 Hollins St

OCT 13 1927 D. HAMPSON JR. M.D.

RRN

(Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.–7-17-26—A Co.—200 Bks.

E 26426

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

E 26426

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals (C.E.) St. 12-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Higgins

(a) RESIDENCE NO. 2007 Maryland ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Bernard Higgins

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Keogh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Hospital Records

(Address)

15 Filed ..... 19.... C. HAMPSON JONES, M. D. Registrar

1927 per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 13, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1927, to Oct. 13 1927,

that I last saw him alive on Oct. 13, 1927,

and that death occurred, on the date stated above, at 3.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

unknown (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. and Clinical

(Signed) T. E. Madden, M. D.

10-18 1927 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial 10/15 1927

20 UNDERTAKER Mary M. Wakefield ADDRESS 501 E. 125th

...should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26427

CERTIFICATE OF DEATH

E 26427

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1840 E. 28th St St., 9-46 Ward)

2-FULL NAME Helen E. Baark

(a) RESIDENCE NO. 1840 E. 28th St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8/1908

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	19	4 3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New York City

PARENTS

10 NAME OF FATHER Ernst Baark

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Hewn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Johanna Baark

(Address) 1840 E. 28th St

15 Filed_____, 19____ C. HARRISON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

Oct 10/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Collier, M. D.
(Coroner)

10-12-27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Western Cemetery	10/14 1927

20 UNDERTAKER Edward Joulson ADDRESS 2353 Wash Blvd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26428

CERTIFICATE OF DEATH.

E 26428

1-PLACE OF DEATH

City of BALTIMORE: (No. 5628 Evergreen Ave. St. Overlea Ward)

Registered No. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Wells

(a) Residence No. 5628 Evergreen Ave St., Overlea Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Wells

6-DATE OF BIRTH (month, day and year) March 2nd 1859

7-AGE. 68 yrs. 7 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer Salvation Army

9-BIRTHPLACE (city or town) (State or Country), Tunbridge England

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown England

12-MAIDEN NAME OF MOTHER, Mary J. Medford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown England

14-(Informant) Alfred Wells

(Address) Walnut Ridge Ave. Overlea

15-Filed ... 192... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 11th 1927

17-I HEREBY CERTIFY, That I attended deceased from Sept 28 1927 to Oct 10 1927

that I last saw h. alive on Oct 10 1927

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(Duration) 1 yrs. 3 mos. ds

CONTRIBUTORY (Secondary) Myocardial degeneracy

(Duration) yrs. mos. 3 ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs Symptoms & Xray

(Signed) Edwin Pendleton M. D.

10/12, 1927 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct 14 1927
20-UNDERTAKER	ADDRESS
Fred Loechner Sons	Fullerton

Exact statement of OCCUPATION is very important. If deceased was in any gainful occupation, state it, even if only part time. Fill in all items, so far as they are known. Please write plainly, and see that the information is properly classified. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26429 E 26429

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 Roslyn Ave WARD 15-W)

2-FULL NAME Emma L. Patten

(a) RESIDENCE NO. 2309 Roslyn Ave St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Shores

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas W. Patten

(Address) 2309 Roslyn Ave

15 Filed Oct 14 1927 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1. 1927. to Oct 12 1927.

that I last saw h alive on Oct 11 1927.

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH was as follows:

Myocarditis and arteriosclerosis.

about 1 yrs. mos ds.

(duration)

CONTRIBUTORY (Secondary) Myocarditis about 1 yr. a cute dilatation 2 days 1

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) Walter Gilbert, M. D.

Oct 13 1927 (Address) 2220 Harrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Oct 14 1927

20 UNDERTAKER George A. Smith — ADDRESS 153 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26430

E 26430

REGISTERED NO. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma North

(a) RESIDENCE NO. Home for Aged of the M. E. Church St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mch 29 1866.

7 AGE — Years: 61 Months: 6 Days: 13. IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Jacob Clark

11 BIRTHPLACE OF FATHER (City or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Elizabeth Aronson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Etta Cuddy

(Address) 400 N. Fulton Ave.

15 Filed ..... , 19 .....

Registrar

OCT 15 1927 C. HAMPSON JONES, M. D.

RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Oct 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1926, to Oct 12, 1927

that I last saw her alive on Oct 11, 1927.

and that death occurred, on the date stated above, at 9.40 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No. What test confirmed diagnosis? Clinical Methods

(Signed) Geo C Shannon, M. D.

10/18, 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — Date of Burial: Oct 14 1927

20 UNDERTAKER: George J Smith — ADDRESS 153 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26431 — 129 — E 26431

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Clementine Sadler.

(a) RESIDENCE NO. Home for Aged of the M. E. Church St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. —mos.— ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15/1853.

7 AGE — Years: 74 — Months: 5 — Days: 27 — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Warner Sadler

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Gilpornh Hopkins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant: Ella Cuddy
(Address) 400 N. Fulton Ave.

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 . 1927 . to Oct 17 . 1927 .
that I last saw h alive on Oct 11 . 1927 .
and that death occurred, on the date stated above, at 6.30 p. m.
The CAUSE OF DEATH* was as follows: 7 p.

Chronic Nephritis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy.
(duration) yrs. 1 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) Geo. B. Shannon . M. D.
10/22 . 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — Date of Burial: Oct 19 1927

20 UNDERTAKER: George J. Smith — ADDRESS 153 Hollins

...should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26432

CERTIFICATE OF DEATH.

E 26432

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Stroun Memorial Hospital St. Ward

2-FULL NAME Addison R. Ruse

(a) RESIDENCE NO. 2101 St Paul St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30, 1849

7 AGE — Years: 78 — Months: 2 — Days: 11 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Addison Ruse

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Louisa Pollard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Harry E Ruse

(Address) 1 E Somerset St Baltimore Md

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Disease
of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Thomsen M. D.
(Coroner)

10/12, 1927 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Hill — Date of Burial: Oct 14 1927

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins

OCT 13 1927

8 A M

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26433

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411 Foster ave ST., 1-W WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Schmitt

(a) RESIDENCE NO. 307 S Ellwood ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Sabastian Schmitt

6 DATE OF BIRTH (month, day, and year) Nov 9 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeping

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Feck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) George Smith 307 S Ellwood ave

15 Filed Oct 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Sep 10 1926 to Oct 12 1927.

that I last saw h[illegible] alive on Oct 11 1927

and that death occurred, on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis + Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart symptoms

(Signed) [illegible] M. D.

10-12-1927 (Address) 307 S Ellwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart

DATE OF BURIAL: Oct 12 1927

20 UNDERTAKER: Wendell Oeffel's Son

ADDRESS: 378 N

TION is very important See instructions on back of certificates.

E 26434

HEALTH DEPARTMENT---CITY OF BALTIMORE

E 26434

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 583 Prestman St. WARD)

2-FULL NAME Charles J. Berkeley

(Residence in Baltimore: No. 583 Prestman St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Colr	Marrd

6-DATE OF BIRTH: Dont Know 1863 (Month) (Day) (Year)

7-AGE: 64 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

9-BIRTHPLACE (State or country): Balto City

PARENTS

10-NAME OF FATHER: Chas J Berkley

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (State or country): U S A

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Corbie Berkeley

(Address) 583 Prestman

15-

Filed ..... 191 .....

C. HAMPSON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 16, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from for several years, 191.., to, Oct 20 1927, that I saw h.. alive on Oct 5 1927, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Previous attack a few years

(Duration) yrs. mos. ds.

(Signed) J K Jones M D

10-13, 1927 [Address] 117 W Saratoga St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Oct. 17. 1927

20-UNDERTAKER: Chas. E. Alexander

ADDRESS: 1406 Druid Hill

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26435

E 26435

113

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 414 S Chester St. St. 2-4 Ward)

2-FULL NAME Apolonia Cos

(a) RESIDENCE NO. 414 S Chester St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28 1926

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	1	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Cos

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Eysk

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Poland

14 Informant Frances Cos

(Address) 414 S Chester St.

15 Filed _____ 19 _____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

No Gastric Cause of Death.

(Duration) yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 1 hr. M. D.

(Signed) G C Kratz (Coroner)

13 1927 (Address) 143 N Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial Oct 14 1927

20 UNDERTAKER John M Weber ADDRESS 1313 Bank St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Maria Bonus

Mercia Boswell

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26436 — CERTIFICATE OF DEATH — 60-001 — E 26436

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. University Hosp. St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boswell, Mercia

(a) RESIDENCE NO. Shepherdstown, W. Va St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Boswell, Ashton E.

6 DATE OF BIRTH (month, day, and year): 1876, Aug 13,

7 AGE — Years: 51 — Months: 2 — Days: 1 — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Knode, Geo. W.

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Walters, Martha

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): unknown

14 Informant: Hospital Records

(Address)

15 Filed ____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 10-14-27

17 I HEREBY CERTIFY, That I attended deceased from 9-14-27, 19____, to 10-14, 1927,

that I last saw h[illegible] alive on 10-14-27, 19____,

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism with toxicity

(duration) yrs. unknown mos. ds.

CONTRIBUTORY (Secondary): Post operative thyroid storm

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 10-10-27

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Teague, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shepherdstown W. Va — Date of Burial: Oct 14 19

20 UNDERTAKER: Harry H. Wirtz — ADDRESS: 1531 W. Lombard St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 14 1927

Spec.—1-12-23—M&T—500 Bks.

E 26437 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3658 Cedar Ave ST. 13-52 WARD)

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas L. Harris

(a) RESIDENCE No. 3658 Cedar Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Late Sarah L. Harris

6 DATE OF BIRTH (month, day, and year) Nov 12, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	10	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George W. Harris (Address) 3658 Cedar Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12, 1927

17

I HEREBY CERTIFY, That I attended deceased from ~~Sept~~ Oct 19~~4~~ . 1927 . to Oct 12* . 1927 .

that I last saw h~~i~~s alive on Oct 11* . 1927

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis and Chronic nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas Orndorff M. D.

Oct 17, 1927 (Address) 846 W 36 St - Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden — DATE OF BURIAL Oct 14, 1927

20 UNDERTAKER Funeral Director — ADDRESS 3615 Roland Ave

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Reynolds

Cor.—12-9-25—A Co.—200 Bks.

Reynolds

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 26438

CERTIFICATE OF DEATH.

E 26438

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 Bruce St. 14-20 Ward)

2-FULL NAME Estel Reynolds

(a) RESIDENCE NO. 1412 Bruce St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Herbert

6 DATE OF BIRTH (month, day, and year): about 1893

7 AGE — Years: 34 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): S. C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry)
and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic History

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

(Address) 25 N Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: Oct 13 192 7

20 UNDERTAKER: Hart Easton — ADDRESS 916 E

Don't fail to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 14 1927 HAMBLETON

Mrs Fannie Smith

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26439

CERTIFICATE OF DEATH.

REGISTERED NO. E 26439

1-PLACE OF DEATH

City of BALTIMORE: (No. 12 N. Amity St. 18-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Johnson

(a) RESIDENCE NO. 12 N. Amity St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	C	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Clinton Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Snowden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs E Snowden

(Address) 12 N Amity St

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Hepatitis

(Duration) yrs. 3 mos. ds.

Cirrhosis

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 ds.

Signed J C Hades M. D.

(Coroner)

10/13/27 Address 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Oct 14 1927

20 UNDERTAKER Samuel Easton ADDRESS 916 Eo ave.

IMPORTANT: Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26440

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

100-001

E 26440

REGISTERED NO.

City of BALTIMORE: (No. 1230 Mc Culloh St. 11-24 Ward)

2-FULL NAME Eva Goldman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 1230 Mc Culloh St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Goldman

6 DATE OF BIRTH (month, day, and year): About 1900

7 AGE — Years: 27 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquest, autopsy or inquiry, find that said deceased came to

on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): endocarditis

(duration) yrs. mos. ds.

(Signed) J. T. Kenney M. D.

(Coroner)

1927 (Address) 2572 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Millsville md — Date of Burial: Oct 13 1927

20 UNDERTAKER: Wm A Easton — ADDRESS 4/6 Dea

Use should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26441

CERTIFICATE OF DEATH.

31 ✓ E 26441

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 14 East Hill ST. 92-6 WARD)

2-FULL NAME Mary E Morrison

(a) RESIDENCE NO. 14 E Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Samuel Morrison

6 DATE OF BIRTH (month, day, and year): May 3. 1873

7 AGE — Years: 54 Months: 5 Days: 7 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Barnabus Bolton

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Eliz Bird

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Samuel Morrison

(Address): 14 East Hill St

15 Filed , 19 RLH, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Oct 12, 1927, that I last saw h[illegible] alive on Oct 12, 1927, and that death occurred, on the date stated above, at 5:25 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

from Cavity

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Mosharrafa, M. D.

Oct 13, 1927 (Address) 3600 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Oct 15 1927

20 UNDERTAKER: W. M. Cook — ADDRESS: 502 E Monument

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26442 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26442

CERTIFICATE OF DEATH.

109-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1943 Patterson Place ST. 8-16 WARD)

2-FULL NAME Mable C Wilson

(a) RESIDENCE NO. 1943 Patterson Place ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	7	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles E Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Caroline E Diebuch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Charles E Wilson

(Address) 1943 Patterson Place.

15 Filed ..... 19 ..... Registrar

OCT 14 1927 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/12 1927, to 10/12 1927.

that I last saw her alive on 10/12 1927

and that death occurred, on the date stated above, at 7 A m

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency 2 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) David Miller, M. D.

10/13 1927 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old St Paul Cemetery DATE OF BURIAL Oct 14 1927

20 UNDERTAKER Robt J Turner ADDRESS 1502 N Broadway

TION is very important See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26443

CERTIFICATE OF DEATH.

38 y

E 26443 REGISTERED NO.

1-PLACE OF DEATH Balto City Hospital

City of BALTIMORE: (No. Balto Md St. 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Leaman

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE: Years 30 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospital

(Address) Balto Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/7 - 19 27

17 I HEREBY CERTIFY, That I attended deceased from 2-12- 19 27 to 10/7 19 27

that I last saw him alive on 10/7 19 27

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lueti Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Serological

(Signed) Harry Goldstein, M. D.

10/8, 19 27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — Date of Burial 10/14 1927

20 UNDERTAKER: J J Fahey Son — ADDRESS 1765 Eight St

OCT 14 1927 REGISTERED

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26444 — 1-PLACE OF DEATH

90 E 26444 — REGISTERED NO.

City of BALTIMORE (No. 4016 Belle Ave. St. 15-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Steinberger

(a) RESIDENCE NO. 4016 Belle Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Steinberger

6 DATE OF BIRTH (month, day, and year) Jany. 22nd. 1860.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Metal & Iron Works.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.

(State or country) Md.

PARENTS

10 NAME OF FATHER Marion Steinberger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER ------Einstein.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Rachel Steinberger

(Address) 4016 Belle Ave.

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

.....find that said deceased came to death
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY
(Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
(Coroner)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Date of Burial

Cheb Shalom Cemetery 10/14/ 1927

20 UNDERTAKER David Sondheim ADDRESS 1520 W. Mt. Royal Ave.

To be stated EXACTLY. PHYSICIANS should be stating, in addition to technical terms, the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26445

CERTIFICATE OF DEATH

E 26445 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Lake Drive & Linden Ave. Riviera Apts. 5 E. St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Weinberg.

(a) RESIDENCE NO. Riviera Apts. 5 E. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Weinberg.

6 DATE OF BIRTH (month, day, and year) June 20, 1858.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	69	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Heiman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Betty Nusbaum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. Max Weinberg

(Address) Riviera Apts. 5 E.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1927, to Oct 12, 1927, that I last saw h.. alive on Oct 12, 1927, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis + arterio-sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lentz, M. D.

10/13, 1927 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	Date of Burial
Baltimore Hebrew Cem.	10/14/ 1927
20 UNDERTAKER	ADDRESS
David Sondheim	1-10 W. Mt. Royal Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26446 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 756 W Henry St. ST. 22-20 WARD)

REGISTERED NO. 16-892

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy L. Mudd.

(a) RESIDENCE No. 526 Portland ST, WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life time yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wh.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19th 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Horace A. Mudd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Hattie Hagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hattie Mudd. (Address) 526 Portland St

15 Filed , 19 Per Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 9. 1927. to Oct 12. 1927.

that I last saw her alive on Oct 12. 1927.

and that death occurred, on the date stated above, at 9.55 p.m.

The CAUSE OF DEATH* was as follows:

Convulsions.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute dysentery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Spielmeyer M. D.

(Address) 682 W Lafayette Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Oct 14 1927

20 UNDERTAKER Chas Lambert & Son

ADDRESS 525 Lynchurst St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26447

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31

E 26447

REGISTERED NO.

City of BALTIMORE: (No. 3026 Dillon St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Lewkliuski

(a) RESIDENCE NO. 3026 Dillon St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Peliza Lewkliuska

6 DATE OF BIRTH (month, day, and year) Oct 22-1888

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Catcher

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) Pennsylvania

(State or country)

PARENTS

10 NAME OF FATHER Stanislaus Lewkliuski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Josephine Zatorowska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland.

14 Informant Peliza Lewkliuska

(Address) 3026 Dillon St.

15 Filed ..... 19 ..... R H K Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cut I. J.

(Duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

Oct 13 (Signed) G. C. Grades M. D.

, 19 (Address) 43 N. Bway (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. Date of Burial Oct 17 1927.

20 UNDERTAKER George A. Weber ADDRESS 2205 Bank st

Don should be carefully supplied. AGE should be EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 26448

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 88 E 26448

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] St. [illegible] Ward) 26-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Charles

(a) RESIDENCE NO. Riverwood 260 Dundalk St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Pick & shovel

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Isaac

11 BIRTHPLACE OF FATHER (City or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Jeanette

13 BIRTHPLACE OF MOTHER (City or town) Va

(State or country)

14 Informant

(Address)

15 Filed [illegible] 19 [illegible] Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-11 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-5, 1927, to 10-11, 1927,

that I last saw him alive on 10-11, 1927,

and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, acute

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy Partial Urinary Retention (?)

(duration) [illegible] yrs. mos. 6 (?) ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) C. Holmes Ford, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary — Date of Burial 10/14 1927

20 UNDERTAKER Mrs R A Elliott — ADDRESS 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26449

CERTIFICATE OF DEATH.

#47

REGISTERED NO. E 26449

1-PLACE OF DEATH

City of BALTIMORE: (No. 108 E. Clement St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna B. Coursey.

(a) RESIDENCE NO. 108 E. Clement St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 0 mos. 26 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	White.	Married.

5a If married, XXXXXXXXXXXX (or) WIFE of Wilbur T. Coursey.

6 DATE OF BIRTH (month, day, and year) September 17, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Carl Wenzel.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Reitz.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Charles H. Coursey. (son)

(Address) 108 E. Clement St.

15 Filed....., 19..... Registrar

OCT 14 1927 Per R.M.M.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 12, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Breasts.
Acute dilatation of the Heart.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

10/14 1927 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial Oct 14 1927

20 UNDERTAKER Margaret E. Flynn ADDRESS 1442 Light St.

(Physician should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26450

38 E.26450

CERTIFICATE OF DEATH.

REGISTERED NO. E 26450

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 6-9 Ward)

(If death occurred in a hospital or institution, give NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Foote Hampton

(a) RESIDENCE NO. 1519 E. Fayette St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory

(b) General nature of industry, business, or establishment in which employed (or employer) Rags

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N.C.

PARENTS

10 NAME OF FATHER Robert Foote

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N.C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Sallie Smith

(Address) 1523 E. Fayette St

15 Filed 19 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said Inquiry find that said deceased came to her death on the day stated above.

(Inquest, autopsy or inquiry.)

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Syphillitic Heart (myocardium)

(Autopsy at Hopkins)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Potter M. D.

(Coroner)

10-15-27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery Date of Burial 10 19 27

20 UNDERTAKER Edward Bryan ADDRESS 1691

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 26451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88-003

E 26451

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Univ Hospital St. 14-24 (Ward)

2-FULL NAME Dorothy L De Hoff

(a) RESIDENCE NO. 206 ~~W Gilmor~~ St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6 1917

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	10	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Jesse McHoff

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Summers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Jesse McHoff

(Address) 206 S. Edney St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Coroner, autopsy or inquiry.) find that said deceased came to her death on the day stated above. The CAUSE OF DEATH was as follows:

Contusion

Fracture of Skull

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Oct 11 1927 (Signed) G C Yates M. D.

(Address) 1431 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Oct 14 1927

20 UNDERTAKER Harry H Nutzle ADDRESS 1531 N Fremont St

(If not buried, cremated or removed, this certificate will be void.)

OCT 12 1927 C H JONES M

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

Peter H. Herndon.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26452

E 26452

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 129

City of BALTIMORE: (No. 1 Mercy Hospital St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter H Herndon

(a) RESIDENCE NO. 210 W. Preston St. St. — Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: mal

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Herndon.

6 DATE OF BIRTH (month, day, and year): unknown. 1873

7 AGE: Years 54 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Oxford N.C.

PARENTS

10 NAME OF FATHER: Silas Herndon

11 BIRTHPLACE OF FATHER (City or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Charles H. Herndon.

(Address): 2448 Mc Culloh St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 10-12-27

17 I HEREBY CERTIFY, That I attended deceased from 9-29-27 19 to 10-12-27 19.

that I last saw him alive on 10-12-27 19.

and that death occurred, on the date stated above, at 8 00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia and Apoplexy (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) [illegible] M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery. Date of Burial: Oct 14 1927

20 UNDERTAKER: Thomas E. Kelson. ADDRESS 1303 Presstman St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26453
1-PLACE OF DEATH

CERTIFICATE OF DEATH

Parkville 100-001

E 26453
REGISTERED NO.

CITY OF BALTIMORE: (NO. 47 Rosekamp Ave ST. 21st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Lorraine Anderson

(a) RESIDENCE. NO. 47 Rosekamp Ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept 25 1927

7 AGE — Years — Months — Days: 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Gustave Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Myrtle Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Harry Krause 47 Rosekamp Ave

15 Filed — 19 — Registrar

Per RMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1927, to Oct 13, 1927, that I last saw h alive on Oct 12, 1927, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) — Malnutrition

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C Burnside M.D.

10/13 1927 (Address) 1279 William St M.D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — DATE OF BURIAL: Oct 15 1927

20 UNDERTAKER: John J Comas & Son. — ADDRESS: 901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26454
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED No. E 26454

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No.) South Baltimore General Hospital (Ward)

2-FULL NAME William Miclowski.

(a) RESIDENCE NO. 1415 Lowman St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) February 27, 1926.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Gustav Miclowski.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Philadelphia Pa

12 MAIDEN NAME OF MOTHER Margaret Johnson.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Gustav Miclowski. (father)

(Address) 1415 Lowman St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 12, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (If inquest, autopsy or inquiry.) and inquest and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Vertebrae. (neck)
Struck, knocked down and run over by an auto-truck. Homicide.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

Signed Otto Reinhardt M. D.
(Coroner)

10/14 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? In front of 1415 Lowman St 10/11/27

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wd Lawn Cem Date of Burial 10 1927

20 UNDERTAKER ADDRESS

W. Cook 07 E Monument

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26455

CERTIFICATE OF DEATH

100-004 E 26455

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3513 Newland Road, Guilford St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Frederica Volkmar

(a) RESIDENCE NO. 3513 Newland Road, Guilford St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): March-22-1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	67	6	9 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: George D. Volkmar

11 BIRTHPLACE OF FATHER (City or town): ? ?

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa R. Somerlock

13 BIRTHPLACE OF MOTHER (city or town): ? ?

(State or country): Germany

14 Informant: Mrs. F. Seibold (cousin)

(Address) 705 Lennox Street.

15 Filed ..... 19 ..... Registrar

By RHK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1927, to Oct 13 1927, that I last saw her alive on Oct 13 1927, and that death occurred, on the date stated above, at 5.45 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ..... yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. mos. 16 ds.

18 Where was disease contracted

if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Phy Exam

(Signed) Geo Dos Swan M. D.

Oct 14 1927 (Address) 1703 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Druid Ridge Cemetery	Oct-15-27 19
20 UNDERTAKER	ADDRESS
E. STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)	1015 N. NORTH AVE

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 14 1927 C. HARRISON LOWE, M.D.

Spec.–7-17-26—A Co.—200 Bks.

E 26456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

12-50 129 E 26456

1-PLACE OF DEATH

REGISTERED NO. E 26456

City of BALTIMORE: (No. 2 W. 25th. St St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Rachel Bulkley

(a) RESIDENCE NO. 2 W. 25th. St St. Ward Resident

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 73 yrs. 2 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry D. Bulkley

6 DATE OF BIRTH (month, day, and year): July 21st. 1854

7 AGE	Years	Months	Days 21	IF LESS than 1 day ..... hrs. or ..... min..
	73	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Penna.

PARENTS

10 NAME OF FATHER: James Hambleton

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rachel Suel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. Harry B. Hambleton (Nephew)

(Address) 714 Mareitta Place, Washington D. C.

15 Filed ..... 19 .....

Registrar RMH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: October 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19 26, to Oct 12 19 27,

that I last saw her alive on Oct 12 19 27,

and that death occurred, on the date stated above, at 3.20 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Valv. Heart Disease

Chr. Bright's

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron. Arthritis, Deformans (duration) 15 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Elwood Hall Jr. M. D.

10/12 19 27 (Address) 2020 N. Charles

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

Date of Burial: Oct. 14 19 27

20 UNDERTAKER: STEUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh... OF DEATH in plain terms, so that it may be properly classified. Exact statement of C... very important. See instructions on back of certificates.

Willis Booth.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 26457

CERTIFICATE OF DEATH

E 26457

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] Ward) 10-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willis Booth.

(a) RESIDENCE NO. 2725 Mt. Pleasant St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	60.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waterman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Jacob Booth

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rebecca Jane ?

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Maryland

14 Informant .....

(Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 ..... Registrar

OCT 14 1927 C. HARRISON JONES, M. D.

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1927, to Oct 13, 1927, that I last saw him alive on Oct 13, 1927, and that death occurred, on the date stated above, at 12.30 A.m.

The CAUSE OF DEATH* was as follows:

myocarditis chronic & acute
arteriosclerosis
hypertension

(duration) ..... yrs. 1 mos. ..... da.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Lab

(Signed) C. Hulmes Bunzel, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Nanticoke Md	Oct 15 1927
20 UNDERTAKER	**ADDRESS**
John C Miller	2435 E. Oliver

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26458

CERTIFICATE OF DEATH.

10-007 E 26158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 532 N. Calhoun St. 14-27 Ward)

2-FULL NAME Anna Macon

(a) RESIDENCE NO. 532 N. Calhoun St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 7 mos. ds. 21 (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 2/17/1917

7 AGE — Years: 10 | Months: 7 | Days: 21 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Earl Macon

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Fannie Wright

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Elizabeth Wright

(Address) 1311 N. Edmondson Ave

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/13/27

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1927, to Oct. 13, 1927, that I last saw h.. alive on Oct. 12, 1927, and that death occurred, on the date stated above, at 1:05 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Diphtheria (duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) John H. Trader, M. D.

, 19 (Address) 1019 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial Oct 15, 1927

20 UNDERTAKER: John H. Trader — ADDRESS 1027 Edmondson Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Mendell)

E 26459

CERTIFICATE OF DEATH.

E 26459

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE; (No.) Sinai Hospital 15-68 (Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Mindell

(a) RESIDENCE NO. 1713 Bentlow St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER: Isaac Mindell

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Rebecca Cohen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Rubin Inman

(Address) 1727 Bentlow St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 - 1927

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to Oct 14, 1927, that I last saw h[illegible] alive on Oct 14, 1927, and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia + Carcinosis

CONTRIBUTORY (Secondary) Senility Hodgkin's disease (duration) 3 yrs. mos. ds.

0 (duration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Biopsy

(Signed) Milton J. Thursky, M. D.

Oct 14 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run Date of Burial: Oct 14, 27

20 UNDERTAKER: S Fenner Bro ADDRESS: Balto

OCT 14 1927

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 26460

CERTIFICATE OF DEATH

E 26460

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [illegible] St. 25-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Sutherns.

(a) RESIDENCE NO. Cherry Hill Branch, Ward ? esqrts.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 91 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	? Widow

5a If married, widowed, or divorced
HUSBAND of ?
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	91			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Braden

11 BIRTHPLACE OF FATHER (City or town)
(State or country) ?

12 MAIDEN NAME OF MOTHER Ann ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant
(Address) Riverside.

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14/ 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1927, to Oct 14, 1927, that I last saw her alive on Oct 14, 1927, and that death occurred, on the date stated above, at 2:20 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gramm's Stain

(Signed) C. Hudson Jones M. D.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — Date of Burial Oct 17, 1927

20 UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

C. HUDSON JONES, M. D.

OCT 14 1927

N. B.—MATTER PRINTED, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 26461

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals 7-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Robertson

(a) RESIDENCE NO. Fremont Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 80 Years Months Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) –

(State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed ..... 19 .....

C. HAMPSON JONES M. D.

Registrar

Par 1200 RFH

3/4 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1927, to Oct 12, 1927, that I last saw him alive on Oct 12, 1927, and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Generalized Osteosclerosis

Chronic Myocarditis

duration Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) H. Bischoff M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND
OCT 14 1927
Commissioner of Health.

Par. F.W. C. Woodall

INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26462

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26462

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No.) Broadway (Street) (WARD) 6-9

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace R. Price

(a) RESIDENCE NO. .... Centreville, Md ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... d
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelia Coston

6 DATE OF BIRTH (month, day, and year) Oct 24-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
82	1875	Oct	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) President of Board County Commissioners Q.A.Co
(c) Name of employer Q. A. Co. Md

9 BIRTHPLACE (city or town) ..... (State or country) Q. A. Co. Md

PARENTS

10 NAME OF FATHER Wm. J. Price

11 BIRTHPLACE OF FATHER (city or town) Q.A.Co (State or country)

12 MAIDEN NAME OF MOTHER Anna Price

13 BIRTHPLACE OF MOTHER (city or town) Q.A. Co. (State or country)

14 Informant Robt. N. Collins
(Address) Centreville Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1927, to Oct 14, 1927, that I last saw h[illegible] alive on Oct 14, 1927, and that death occurred, on the date stated above, at 2.57 a m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Oct 4, 27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George E Bruce, M. D.

10-4-1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Centreville Md

DATE OF BURIAL Oct 16 1927

20 UNDERTAKER Horace F. Bruce

ADDRESS 3631 Falls Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 26463

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161 E 26463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 W. Saratoga ST. 1357 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Nothing

(a) RESIDENCE No. 2004 W. Saratoga ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Oct 13th 1927

7 AGE — Years | Months | Days | If LESS than 1 day hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Geo Nothing

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Bessie Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Bessie Nothing
(Address): 2004 W. Saratoga St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31st 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 13th, 19 27, to Oct 30th, 19 27, that I last saw h[illegible] alive on Oct 31st, 19 27, and that death occurred, on the date stated above, at 1:00 A m.

The CAUSE OF DEATH* was as follows:

Convulsions from birth

1 hour

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. C. Hampson Jones, M. D.

Oct 31 19 27 (Address) 3611 Three Pts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ..... DATE OF BURIAL ..... 19 .....

20 UNDERTAKER ..... ADDRESS .....

Nov 4 1927 Rec 1800 NARA

JOHNS HOPKINS HOSPITAL OCT 1927

C. HAMPSON JONES, M. D.

Health Officer

Station should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26464

CERTIFICATE OF DEATH

44 E 26464

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 12-44 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Engle

(a) RESIDENCE NO. 3423 Guilford Terrace St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Frank Engle

6 DATE OF BIRTH (month, day, and year): Do not know

7 AGE: Years 45 Months — Days — IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Md

PARENTS

10 NAME OF FATHER Edward Donohue

11 BIRTHPLACE OF FATHER (City or town) Frostburg

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie McNulty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Edw. J. Donohue

(Address) 3423 Guilford Terrace

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10/14/27

17 I HEREBY CERTIFY, That I attended deceased from 9/30/, 19 27, to 10/14 19 27,

that I last saw h~~er~~ alive on 10/14 19 27,

and that death occurred, on the date stated above, at 7 55 A m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Liver

(duration) unknown yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? Yes Date of 10/10/27

Was there an autopsy? No

What test confirmed diagnosis? at operation

(Signed) J. H. Linsley, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frostburg, Md. Date of Burial 10/15 1927

20 UNDERTAKER: Henry U. Mearns Son ADDRESS 855 N. Calvert

Via B. & O. Railroad – Escort – Edw. J. Donohue

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26465

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-092

E 26465

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Joseph's Hospital

City of BALTIMORE: (No. Caroline & Oliver St., 9-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby - Mattingly

(a) RESIDENCE NO. Newport (Charles Co) Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 12. 1927

7 AGE — Years — Months — Days — IF LESS than 1 day ....hrs. or 5 min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Abram T. Mattingly

11 BIRTHPLACE OF FATHER (City or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Mary R. Gibbons

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mother
(Address)

15 Filed ....., 19 .....
Registrar

1804

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 - 27 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 19 27 to Oct 12, 19 27,
that I last saw h[illegible]m alive on Oct 12, 19 27,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Asphixia - following delivery - Arm Shoulder presentation

(duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs....mos....ds.

18 Where was disease contracted Hospital -

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos B Peacock M. D.

, 19 (Address) Resident in Obstetrics

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OCT 14 1927

JOHNS HOPKINS HOSPITAL

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26466

CERTIFICATE OF DEATH.

114 E 26466

REGISTERED NO.

1-PLACE OF DEATH Coloring Hosp

City of BALTIMORE: (No. [illegible] St. 21-29 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodor Klein

(a) RESIDENCE NO. 1209 James St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Katherine Klein

6 DATE OF BIRTH (month, day, and year) June 17, 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schmidt Bakery

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER John Klein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Katherine Klein

(Address) 1209 James St

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ac. Dilatation of Heart

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

19 27 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Oct. 15 1927

20 UNDERTAKER Margaret Coffman ADDRESS 1422 Light St

OCT 14 1927

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26467

CERTIFICATE OF DEATH.

E 26467

1-PLACE OF DEATH

REGISTERED NO. 188

City of BALTIMORE: (No. Mercy Hospital. St., 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Brown.

(a) RESIDENCE NO. 1200 Guilford Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If married, widowed, or ~~XXXXXX~~ of ~~XXXXXX~~ Mary Brown.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	92	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retifed fireman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Joseph Brown. (son)

(Address) 1200 Guilford Ave.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 13, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally struck by a street car.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) M. D.

10/14 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Greenmount Ave & Druxton St. Oct. 12, 1927

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery H.R. Date of Burial Oct 15 1927

20 UNDERTAKER Mc Ginnis & Carmel ADDRESS 311 Spedding Ave.

OCT 14 1927 C. HAMPSON JONES, M. D.

PCRA

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26468

CERTIFICATE OF DEATH.

E 26468

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 Pulaski St. 15-68 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wesley Eaton.

(a) RESIDENCE NO. 2001 Pulaski St. ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Lucretia Eaton

6 DATE OF BIRTH (month, day, and year): Sept 30, 1851

7 AGE: Years 76 | Months | Days 13 | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md.

PARENTS

10 NAME OF FATHER: William Eaton

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Nancy Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Charles E. Eaton.

(Address): 2001 Pulaski St

15 Filed ..... 19 .....

Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13, 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1927, to Oct 13, 1927.

that I last saw h[illegible] alive on Oct 13, 1927,

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Interstitial

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic

[illegible] (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. C. Adelsberger M. D.

10/14/27 (Address) 2757 W. Mont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cumberland Md

DATE OF BURIAL: Oct 15 '27

20 UNDERTAKER: Chas. Dion

ADDRESS: 30 S. Eutaw St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26469

CERTIFICATE OF DEATH.

113 E 26469

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 838 - Hampson St. 13-20 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Johnson

(a) RESIDENCE NO. 838 - Hampson St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 26 27

7 AGE — Years: — Months: 1 Days: 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nurse

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Early heights Md

PARENTS

10 NAME OF FATHER W. H. Johnson

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Jensen

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant (Address) Josephine Jernsen 838 Hampson al

15 Filed_____ 19_____ Registrar

OCT 14 1927 C. HAMPSON JOHNSON

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1927, to Oct 11, 1927, that I last saw h.. alive on Oct 11, 1927, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

(duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Johnson, M. D.

19 (Address) 2329 Guilford Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion City Date of Burial: Oct 15 27

20 UNDERTAKER J. Lem Hall ADDRESS 753 Dolphin

Spec.–7-17-26—A Co.—200 Bks.

E 26470

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26470

CERTIFICATE OF DEATH

129

REGISTERED NO. 17-24

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Johnson

(a) RESIDENCE NO. 672 Oxford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. s.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE: 75 Years Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER Chas A Johnson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Caroline

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Balto City Hosp

(Address)

15 Filed ..... 19 .....

C. THOMPSON JONES, M. D. Registrar

NPA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10-11-27

17 I HEREBY CERTIFY, That I attended deceased from 8-12, 1927 to 10-11, 1927, that I last saw him alive on 10-11, 1927 and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiac Vascular Disease

Chronic Interstitial Nephritis

(duration) Indefinite

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H Blanchard, M. D.

. 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — Date of Burial Oct 15 — 27

20 UNDERTAKER: Hunt Easton — ADDRESS Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26471 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26471

CERTIFICATE OF DEATH. 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 14-27 WARD)

2-FULL NAME Charles Waters

(a) RESIDENCE NO. 1622 W. Mulberry st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. d.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or:) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 19

17

I HEREBY CERTIFY, That I attended deceased from July 7, 19 27, to Oct. 13, 19 27,

that I last saw h in alive on Oct. 13, 19 27

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. E. Madden, M. D.

10-14-27 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Oct 15 19 27

20 UNDERTAKER Harris Easton ADDRESS Penn

Instructions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26472

100-001 E 26472

CERTIFICATE OF DEATH.

REGISTERED No. _____

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital St. 15-21 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Smith

(a) RESIDENCE NO. 1429 N. Mount St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lydia Smith

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 49 | Months — | Days — | If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): _____

(c) Name of employer: _____

9 BIRTHPLACE (city or town): _____

(State or country): Va

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Va

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Va

14 Informant: Lydia Smith

(Address): 1429 N. Mount St

15 Filed ..... 19 .....

Registrar

A.H.B.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

about 10 days (duration) Don't Know (Mother's name) N.Y.

CONTRIBUTORY (Secondary)* Pulmon. Edema (duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. J. Jones (Coroner)

Oct 13, 1927 (Address) 1029 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State 3 hrs ago yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Date of Burial Oct 15 1927

20 UNDERTAKER: Daniel Easton ADDRESS 916

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-16-21—M&T—1500 Bks.

E 26473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26473

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 931 W. Lombard ST. (WARD) 18-29

2-FULL NAME Hattie Hobelmann

(a) RESIDENCE No. 931 W. Lombard ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Hobelmann

6 DATE OF BIRTH (month, day, and year) Nov. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
70	71	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred Reulking

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Francis Reulking (Address) 931 W. Lombard St.

15 Filed ... 19 ... Registrar

C. HAMPSON JONES, M. D.

OCT 14 1927

Acd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13th 1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct 10th, 1927, to Oct 13th, 1927.

That I last saw her alive on Oct 13th, 1927.

and that death occurred, on the date stated above, at 11:57 m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urine Analysis Etc.

(Signed) Chas. Norton M. D.

10/14 1927 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL 10/15/1927

20 UNDERTAKER J. A. Moran ADDRESS 320 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 26474

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26474

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 129 W Montgomery ST. 27-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Curtis

(a) RESIDENCE NO. 129 W. Montgomery ST. , WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	Colored.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Curtis,

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60.	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Paint Mfg Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia,

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary Curtis (Address) 109 W. Montgomery

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 19 27.

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to Oct. 12, 1927, that I last saw him alive on Oct. 8, 1927, and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows: Valvular disease of heart.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Hypertrophy & Dilatation of Heart (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown,

Did an operation precede death? No Date of ,

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 1215 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Oct 16 19 27

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 15 1927 C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26475

CERTIFICATE OF DEATH

88 E 26475

1-PLACE OF DEATH

REGISTERED NO. 14-78

City of BALTIMORE: (No. [illegible] St., 14 Ward) BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Standard

(a) RESIDENCE NO. 1621 Argyle Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 56 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm. Downes

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant

(Address): Records

15 Filed ..... 19 .....

Registrar: [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/14/1927

17 I HEREBY CERTIFY, That I attended deceased from 10/11/27, 19 ..., to 10/14/, 19 27

that I last saw h[illegible] alive on 10/14/, 19 27

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, acute,
Hypertension.
Arteriosclerosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory Findings

(Signed) A. Holmes Wright, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial Oct 17 1927

20 UNDERTAKER: Jerome E. Wright — ADDRESS 1364 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26476

CERTIFICATE OF DEATH.

66 E 26476

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2212 Mace St. 12-51 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Spencer Moore

(a) RESIDENCE NO. 2212 Mace St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Virginia Moore

6 DATE OF BIRTH (month, day, and year): July 12 - 1897

7 AGE: Years 30 Months 3 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER: Thos A Moore

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER: Eliza Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant: Horace Smith

(Address) 2212 Mace St

15 Filed....., 19.....

AKB Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h— death on the day stated above.

The CAUSE OF DEATH was as follows: Arteriosclerosis & Paralysis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John H. Ramsey M. D.

(Coroner)

10/14 1927 (Address) 2632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem Date of Burial 10/15 1927

20 UNDERTAKER: Samuel H. Hensley ADDRESS: 1133 Park Ave

CHAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

E 26477

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26477

CERTIFICATE OF DEATH

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

City of BALTIMORE: (No. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Benesman

(a) RESIDENCE NO. 215 S Highland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE: Years 66 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General natnre of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Hugo Benesman

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Keen ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant

(Address): Mrs. Reeds

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/13 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/7, 1927, to 10/13, 1927, that I last saw h— alive on 10/13, 1927 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

Stone

Months (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis Arteriosclerosis

..... (duration) 2 yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) ..... M. D.

, 19 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Oct. 16th 1927

20 UNDERTAKER: Lilly & Sons — ADDRESS: 403 S Mt St

OCT 15 1927 C. HAMPSON JONES M.D.

Dec R.H.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.—200 Bks.

E 26478

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10 E 26478

REGISTERED NO. _____

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 425 N Kenwood St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J Reisen Jr

(a) RESIDENCE NO. 425 N Kenwood St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18 1922

7 AGE Years 5 Months 8 Days 28 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Joseph J Reisen

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Viola C Rines

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Joseph J Reisen

(Address) Joseph J 425 N Kenwood Ave

15 Filed OCT 15 1927 C. HAMPSON JONES, M. D. Registrar

By RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 7 1927 to Oct 15 1927,

that I last saw h alive on Oct 6 1927,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows: Pul. paralysis (Cardiac)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem Date of Burial Oct 16 1927

20 UNDERTAKER John Welsh ADDRESS 2008 Orleans

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26479

CERTIFICATE OF DEATH.

11 E 26479

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 824 W Fayette St. 18-W Ward)

2-FULL NAME John J Barry

(a) RESIDENCE NO. 824 W Fayette St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margretta Barry

6 DATE OF BIRTH (month, day, and year): Sept 25 1860

7 AGE — Years: 63 — Months: — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: City Engineers Dept Lab

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town): Balto

(State or country): .....

PARENTS

10 NAME OF FATHER: William Barry

11 BIRTHPLACE OF FATHER (city or town): .....

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): .....

(State or country): Ireland

14 Informant (Address): Mrs Barry 824 W Fayette

15 Filed ..... 19 ..... Registrar

J. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

*Coronary Sclerosis

Coma of Dist

Duration ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonic

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) C C Wades M. D.

(Coroner)

Oct 5 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: Oct 7 192 7

20 UNDERTAKER: C C Wades — ADDRESS: 1210 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 26480

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26480

CERTIFICATE OF DEATH

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1302 W Lafayette St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Thomas Hurley

(a) RESIDENCE NO. 1302 W. Lafayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Thomas Hurley

6 DATE OF BIRTH (month, day, and year): Nov 7th 1883

7 AGE — Years: 43 Months: 11 Days: 8 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town): Calvert Co.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Wallace

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Thomas White

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant ..... (Address): Mrs. Thomas Hurley 1302 Lafayette

15 Filed ..... 19 ..... Registrar

OCT 15 1927 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 14th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 7th, 1927, to Oct 14th, 1927, that I last saw her alive on Oct 14th, 1927, and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Hemorrhage

(duration) 1 hr 10 min yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Bronchial Asthma

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. E. Self, M. D.

10-15-1927 (Address) 716 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: Oct 17 1927

20 UNDERTAKER: Sam'l H. Chase & Son — ADDRESS: 1910 Mosher

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 26481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 40 E 26481

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Marshall

(a) RESIDENCE NO. 1117 Mc Cullough St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 28 Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER: Walter Cooper

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Tippe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Hattie Cooper

(Address): Md

15 Filed..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

Inquest, autopsy or inquiry, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Salpingitis

Dual Renal (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis Agitans Epilepsy Uremia

(duration) yrs. mos.

Signed W. J. Riley (Coroner)

Oct. 15 19 27 (Address) 16 Bey Bmy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md Date of Burial 10-17 1927

20 UNDERTAKER: Jas. M. Skinner ADDRESS 1626 E. Mad St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 26482

CERTIFICATE OF DEATH

E 26482

1-PLACE OF DEATH St. Joseph's Hospital — REGISTERED NO.

City of BALTIMORE: (No.) St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Gallagher.

(a) RESIDENCE NO. 2520 Baker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~: Mary Gallagher

6 DATE OF BIRTH (month, day, and year): Don't Know

7 AGE: Years 55 Months Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer): O'H

(c) Name of employer

9 BIRTHPLACE (city or town): [illegible]

(State or country): Ireland

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland

14 Informant: Francis Gallagher

(Address) 2520 Boston St

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1927, to Oct 13, 1927.

that I last saw h[illegible] alive on Oct 13, 1927

and that death occurred, on the date stated above, at 11-50 P.m.

The CAUSE OF DEATH* was as follows:

Varicose ulcers - stomach - pneumonia

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Septicemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted: Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Longwell Fenn, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial: Oct 19 27

20 UNDERTAKER: Robt J Garner Sr — ADDRESS: 1 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26483 ✓ 90 E 26483

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Webster King

(a) RESIDENCE NO. 1205 Montford Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Don't Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Don't Know

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't Know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Don't know

14 Informant

(Address) Relative.

15 Filed ____, 19 ____ C. HAMPSON JONES, M. D. Registrar

OCT 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1926, to Oct. 14, 1927, that I last saw him alive on Oct. 14, 1927 and that death occurred, on the date stated above, at 11.15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

Arteriosclerosis.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) 3 yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Symptoms.

(Signed) C. Hampson Jones M. D.

, 19 (Address) [redacted]

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — Date of Burial 10/15 1927

20 UNDERTAKER Chas. H. Grant & Son — ADDRESS [redacted] Madison Ave

Cor.—12-9-26—A Co.—200 Pkm.

Regina M. Schene

HEALTH DEPARTMENT—CITY OF BALTIMORE

26484 E

90 E 26484

CERTIFICATE OF DEATH.

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St., 8-4th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Regina M Schene

(a) RESIDENCE NO. 3405 Elmley Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, ~~Widowed, or Divorced,~~ (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman T. Schene

6 DATE OF BIRTH (month, day, and year) July 6-1895

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frank J. Couzens

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Delia Malcoly

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Balto. & Md.

14 Informant Herman T. Schene

(Address) 3405 Elmley ave

15 Filed..... 19..... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 10-15-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ....yrs. ....mos. ....ds.

(Signed) J. W. Ellis, M. D.

(Coroner)

10-15 19 27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Date of Burial 10 18 1927

20 UNDERTAKER Chas. P. Crane & Son ADDRESS 118 North Royal Ave

NKA

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26485

CERTIFICATE OF DEATH.

3 VE 26485

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 426 Federal St., 12 Ward)

2-FULL NAME Robt Rice

(a) RESIDENCE NO. 426 Federal St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 7 1902

7 AGE: Years 25 Months 7 Days 6 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): do

(c) Name of employer: /

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Wm Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Nannie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Wm Rice

(Address): 426 Federal

15 Filed....., 19.....

Pa. RPH Registrar

OCT 15 1927 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) W. F. Peters (Coroner)

Oct 13 1927 (Address) 1037 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Glendale Va. Date of Burial Oct 15 1927

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS 1325 Eastland Av.

S. H.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26486

CERTIFICATE OF DEATH.

E 26486

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp. 19-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calaydon Wilburn

(a) RESIDENCE NO. 1601 W. Mulberry St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Pleato Wilburn

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ga

12 MAIDEN NAME OF MOTHER Maggie Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ga

14 Informant Pleato Wilburn

(Address) 1601 W. Mulberry

15 Filed ....., 19 .....

ARH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Circ (Inquest, autopsy or inquiry) find that said deceased came to h s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchos Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. F. Hennessy, M. D.
(Coroner)

Oct. 15 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial Oct 15 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 1303 Pressman St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 26487 HEALTH DEPARTMENT—CITY OF BALTIMORE 26487

CERTIFICATE OF DEATH.

90 E 26487

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Valley St., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Micheal H. Calon

(a) RESIDENCE NO. 1020 Valley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary F. Calon (nee O'Brien)

6 DATE OF BIRTH (month, day, and year): Mar. 30 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5-6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Labor.

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer: City Water Dept.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Micheal Calon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Isabella McClelland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mrs. Mary F. Calon (Wife)

(Address): 1020 Valley St

15 Filed OCT 16 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Augs 10, 1927, to Oct. 14, 1927, that I last saw him alive on Oct. 14, 1927, and that death occurred, on the date stated above, at 12:5 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Stethoscope.

(Signed) Mary F. Calon M. D.

Oct 15 1927 (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Oct. 1927

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 9248 Eager St.

INFORMATION, WRITE PLAINLY IN INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26488

E 26488

CERTIFICATE OF DEATH.

113 E 26488

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No.) 4410 Belair Rd. St.) 27-H (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lester Reynolds

(a) Residence No. 4410 Belair Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6-DATE OF BIRTH (month, day and year) Feb. 12, 1927

7-AGE. ....yrs. 8 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS:

10-NAME OF FATHER, Wm J. Reynolds

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Helen S. Finch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14-Informant, Wm J. Reynolds

(Address) 4416 Belair Rd.

15-

Filed ....., 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-14-27

17- I HEREBY CERTIFY, That I attended deceased from 10/10 1927 to 10/14 1927 that I last saw him alive on 10/14 1927 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency 2

(Duration) ....yrs. ....mos. ....ds

CONTRIBUTORY (Secondary) Chronic Colitis

(Duration) ....yrs. ....mos. 8 ....ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Dane Bullock M. D.

10/14 1927 (Address) 1420 Edwards

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cemetery DATE OF BURIAL. Oct. 17, 1927

20-UNDERTAKER. Elmer W. Conklin ADDRESS 924 E Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26489

CERTIFICATE OF DEATH.

45 E 26489

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 62 Gorman Ave. 10-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie T Maloney

(a) RESIDENCE NO. 62 Gorman Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E Maloney

6 DATE OF BIRTH (month, day, and year) Feb 7 1862

7 AGE Years 65 | Months 8 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Patrick Carahan

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Murray

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Nellie Maloney

(Address) 62 N Gorman Ave

15 Filed ... 19 ... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14. 1927

17

I HEREBY CERTIFY, That I attended deceased from August, 1927. to Oct. 14, 1927.

that I last saw her alive on Oct. 13, 1927.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. S. Howe M. D.

(Address) 176 Collington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem | DATE OF BURIAL 10/17 1927

20 UNDERTAKER Geo A Farley Fulton | ADDRESS 1 Fayette

OCT 16 1928

INFORMATION, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26490

CERTIFICATE OF DEATH.

E 26490

21-2975-C

1-PLACE OF DEATH

City of BALTIMORE: (No. 1124 W. Cleveland St. St., 21 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M. Fleury

(a) Residence No. 1124 W. Cleveland St. St., 21 Ward.
(Usual place of abode) (If non-resident give city or town and state)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed or Divorced, (write the word.): widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Fleury

6-DATE OF BIRTH (month, day and year): Feb. 14, 1849

7-AGE: 78 yrs. 8 mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: John Utz

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Not ~~Known~~ Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Mr. Harry Fleury

(Address): 1124 Cleveland St.

15-

Filed 1927 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 10/14/27

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1921 to Oct. 1927, that I last saw h... alive on Sept, 1927, and that death occurred, on the date stated above, at 9. a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John C. Schwarzburg M.D.

, 19 (Address) 1126 W. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon P K Cemetery — DATE OF BURIAL: 10/17/27

20-UNDERTAKER: Geo Leumbach & Son — ADDRESS: 525 N. Lyndhurst St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26491

CERTIFICATE OF DEATH.

E 26491 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 420 Sipple ave. Raspeburg St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Giese

(a) Residence No. 420 Sipple ave. Raspeburg St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Louise D. Giese

6-DATE OF BIRTH (month, day and year): March 12th 1854

7-AGE: 73 yrs. 7 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 15 years

(c) Name of employer:

9-BIRTHPLACE (city or town) Unknown (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Unknown (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country), Unknown

14- (Informant) Elizabeth Compton

(Address) 40 Powell ave. Raspeburg

15- Filed Oct 16 1927, 19 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Oct. 14th 1927

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1927 to Oct 14 1927

that I last saw him alive on Oct 14 1927,

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 3 yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustave A. Kiefer M. D.

10/14, 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Oct 17th 1927

20-UNDERTAKER: Frederick Lassahn — ADDRESS: Fulton

Spec.-7-17-26—A Co.—200 Bks.

E 26492

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 26492

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

1-PLACE OF DEATH

City of BALTIMORE: (No. 613 E.Thirty-Sixth Street St., 9-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E.Wolf.

(a) RESIDENCE NO. 613 E.Thirty-Sixth Street St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Louis Wolf.

6 DATE OF BIRTH (month, day, and year) December 12,1861

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town)

(State or country) Baltimore,MD

PARENTS

10 NAME OF FATHER Frederick Neubert

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Estella King

(Address) 613 E.Thirty-Sixth St

15 Filed , 19 Registrar

OCT 16 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1927 19

17 I HEREBY CERTIFY, That I attended deceased from May, 1927, to Oct 14, 1927, that I last saw h alive on Oct 14, 14, 1927, and that death occurred, on the date stated above, at 12.30Am.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation of heart.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? c

(Signed) C J Strickler Jr, M. D.

Oct 15, 1927 (Address) 632 Fawn ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
Loudon Park Cemetery	Oct 17,1927
20 UNDERTAKER Joo Jourdens + Son	ADDRESS 317 S.Paca St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26493

CERTIFICATE OF DEATH

× 90 E 26493

REGISTERED NO. 4-25

1-PLACE OF DEATH

City of BALTIMORE: (No. 666 W. Baltimore Street. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jane Sipe

(a) RESIDENCE NO. Thornton West Virginia St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late John Sipe

6 DATE OF BIRTH (month, day, and year) Febuary 2,1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	77	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Montrose

(State or country) West Virginia

PARENTS

10 NAME OF FATHER Henry Harris

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Nancy Furgerson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Troy E. Auvill

(Address) 666 W. Baltimore St

15 Filed OCT 15 1927 19 C. HAMPSON JONES M. D. Registrar

Per RUL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14,1927 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1927, to Oct 14 19 27,

that I last saw her alive on Oct 14 19 27

and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows: Myocarditis Chronic

(duration) One yrs. X mos. X ds.

CONTRIBUTORY (Secondary) X

(duration) X yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. Burt Williams M. D.

, 19 (Address) 601 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Junior, West Virginia — Date of Burial: Oct 16, 1927 19

20 UNDERTAKER: Jos Jourdan & Son — ADDRESS: 217 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Blks.

E 26494

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26494

CERTIFICATE OF DEATH.

153

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 127 W. Clement ST. 23-31 WARD)

2-FULL NAME Edwin H. Clipper.

(a) RESIDENCE NO. 127 W. Clement ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March, 3, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	16,	7,	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md. Dental Laboratory.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edwin H. Clipper. Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Florence A. Lewis.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Florence A. Clipper.
(Address) 127 W. Clement Street.

15 Filed ....., 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1927, to Oct 15, 1927, that I last saw h/m alive on Oct 14, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Abscess Harm -

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

10/15/1927 (Address) 6 Randall Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL Oct 18, 1927

20 UNDERTAKER A. Howard Evans ADDRESS 38 E Fayette

NAME PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

OCT 15 1927 C. HAMPSON JONES, M.D.

Spec.—1-12-23—M&T—500 Bks.

Dr Beckley 126 W Belvedere Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26495 E 26495

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5309 Garrison Ave ST. Arlington 27 (WARD) 92

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice D Ward

(a) RESIDENCE No. 5309 Garrison Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of James H. Ward

6 DATE OF BIRTH (month, day, and year) Jan 25 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Barney Dilley

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Dilley

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant A C Ward

(Address) 5309 Garrison Ave

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1927, to later in day, that I last saw h alive on Oct 15, 1927, and that death occurred, on the date stated above, at 6:00 P m.

The CAUSE OF DEATH* was as follows:

Embolism of Coronary Artery

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. A. Beckley, M. D.

, 19 (Address) 126 W Belvedere Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Neighong Cem, Frostburg, Md — DATE OF BURIAL Oct 17 19 27

20 UNDERTAKER W M Cook — ADDRESS 502 E North Ave

AUG 16 1927 C. HAMILTON JONES, M. D.

Registrar

INSTRUCTIONS—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Lillian Snyder

E 26496.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26496.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 22-30 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Libbie Snyder

(a) RESIDENCE NO. 725 Washington Blvd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1915

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	12	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Balto city Md

(State or country)

10 NAME OF FATHER Sam Snyder

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Hoffman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Sam Snyder

(Address) 725 Washington Blvd

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coma Caused by Pneumonia 2 hrs Prior 2 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Oct 16 1927 (Signed) G E Slade M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lebrun Mt Comel — Date of Burial Oct 16 1927

20 UNDERTAKER Keck Lewis — ADDRESS 1739 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 19 1927 HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26497
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

164 **E 26497**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2823 Frisby ST. 9-46 WARD)

2-FULL NAME Ann Wain Ross

(a) RESIDENCE No. 2823 Frisby ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? 80 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James David Ross

6 DATE OF BIRTH (month, day, and year) November 28, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	86	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Cheese dealer.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oxfordshire England

PARENTS

10 NAME OF FATHER William Wain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oxfordshire England

12 MAIDEN NAME OF MOTHER Ann Waite

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oxfordshire England

14 Informant Mary Mead Dean, M.D.
(Address) 901 N. Calvert St.

15 Filed — 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15 1927

17 I HEREBY CERTIFY, That I attended deceased from October 2 1927, to October 15, 1927, that I last saw her alive on October 14, 1927 and that death occurred, on the date stated above, at 12.00 a.m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) Mary Mead Dean, M. D.

, 19 (Address) 901 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent's Cemetery	10/19 1927
20 UNDERTAKER Henry A. Wears	ADDRESS 1705 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1 12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26498

CERTIFICATE OF DEATH.

31

E 26498

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. C.H. 6-14 WARD)

2-FULL NAME Daniel Manning

(a) RESIDENCE No. 2037 Fairmount ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James H. Manning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Buckley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records
(Address)

15 Filed ..... 19 C. HAMPSON JONES, M.D. Registrar

OCT 17 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14, 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1927, to Oct. 14, 1927,

that I last saw him alive on Oct. 14, 1927

and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) S. E. Madden M. D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL Oct. 17 1927

20 UNDERTAKER Henry Sauder & Sons Inc

ADDRESS 1710 Fleet St.

Spec.—1-12-23—M&T—500 Bks.

Akers

E 26499 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26499

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1611 John ST. 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Robt. Akers Jr.

(a) RESIDENCE No. 1611 John ST. ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Akers

6 DATE OF BIRTH (month, day, and year): May 28 1854

7 AGE: Years 73; Months 4; Days 16; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Joseph Akers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Ann Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Rosa J. Akers

(Address): 1611 John St

15 Filed OCT 17 1927, 19 ..... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10 - 14 1927

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 13, 1927,

that I last saw h[illegible] alive on Oct 13, 1927,

and that death occurred, on the date stated above, at 11 85 m

The CAUSE OF DEATH* was as follows:

Hemiplegia

CONTRIBUTORY (Secondary): Hypostatic congestion (duration) ..... yrs. mos 13 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) H. C. Jones, M. D.

, 19 (Address) 320 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 10 - 17 1927

20 UNDERTAKER: Bernard C Starke — ADDRESS: 1800 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26500 E 26500

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 749 Carroll ST., 2124 WARD)

2-FULL NAME Margaret McCain

(a) RESIDENCE NO. 749 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): June 6 1927

7 AGE: Years 0 Months 4 Days 10 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Larkin L McCain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sophia Quantmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Larkin L McCain

(Address) 749 Carroll St

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-16 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1927, to Oct 15, 1927,

that I last saw h[illegible] alive on Oct 15, 1927

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) diarrhoea and

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) [illegible] Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn. DATE OF BURIAL 10 17 1927

20 UNDERTAKER: Bernard C Hahn ADDRESS 1040 S Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT FOLD OR ROLL—USE FOR BINDING

C. HAMPSON JONES, M.

OCT 17 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26501

E 26501

CERTIFICATE OF DEATH

129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 W. Montgomery St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Cornish

(a) RESIDENCE NO. 114 W. Montgomery St. 22 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'

4 Color or Race: ed

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — — 1871

7 AGE: Years 56 Months — Days — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Cook 021

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Edna Slocum

(Address) 114 W. Montgomery

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13/ 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/81, 1927, to 10/13/27, 1927

that I last saw h[illegible] alive on 10/12/27, 1927

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Interstitial nephritis

(Rheumatic) about (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical symptoms

(Signed) J. Bowley, M. D.

10/13/1927 (Address) 708 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct — Date of Burial: Oct 17 1927

20 UNDERTAKER: [illegible] & Brown, N. Eut — ADDRESS: 1618 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26502 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26502

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. 844 Sharp St. 22-30 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Matthews

(a) Residence No. 844 Sharp St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col.

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE. 44 yrs. 9 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work [illegible]
(b) General nature of Industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Charlotte Co., Va.

PARENTS:
10-NAME OF FATHER, unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.
12-MAIDEN NAME OF MOTHER, Emma Porter
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14- (Informant) Rosa Matthews
(Address) 844 Sharp St.

15- Filed OCT 17 1927 192... C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 13 27

17- I HEREBY CERTIFY, That I attended deceased from Oct 9 19 27 to Oct 13 19 27
that I last saw h[illegible] alive on Oct 13 19 27
and that death occurred, on the date stated above, at 11:30 m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(Duration) 7 yrs. 1 mos. 7 ds.
CONTRIBUTORY (Secondary) Chronic Cystitis
(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? [illegible]
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Urinalysis
(Signed) C. Hampson Jones M. D
10/17 19 27 (Address) 1701 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn
DATE OF BURIAL. 10/19 19 27

20-UNDERTAKER. J. H. Wood & Son
ADDRESS 1700 Druid Hill Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... instructions on back of certificates.

Cor.—12-...

Cor.—12-9-25—A Co.—200 Bks.

E 26503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 26503

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St., 4-16 Ward)

2-FULL NAME Robt Moesta

(a) RESIDENCE NO. 738 W. Balto., Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 1; Months; Days 7; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER Henry Moesta

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.

(State or country)

12 MAIDEN NAME OF MOTHER Cora

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Hopkins

(Address)

15 Filed 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dysentery - Contra-intestinal lesion

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Collins M. D.

10-19-27 (Address) 508 E. North Ave (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Date of Burial 10/17/27

20 UNDERTAKER Joseph Adams ADDRESS 221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMA... PHYSICIANS should... ties should be carefully... OF DEATH in plain terms, so... very important. See instructions on back of certificate... Exact statement of OCCU...

OCT 17 1927 C. Hamilton M.D.

Cor —12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Cor—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26504

CERTIFICATE OF DEATH.

90 E 26504

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3421 Chestnut St. 23 Ward)

2-FULL NAME Charles E. Bailey

(a) RESIDENCE NO. 3421 Chestnut St. 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah S. Bailey.

6 DATE OF BIRTH (month, day, and year): May 27, 1866

7 AGE: Years 61 Months 5 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mill Wright

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Co.

(State or country)

PARENTS

10 NAME OF FATHER: John D. Bailey

11 BIRTHPLACE OF FATHER (city or town): Balto Co

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Cook

13 BIRTHPLACE OF MOTHER (city or town): Balto Co.

(State or country)

14 Informant: Sarah S. Bailey

(Address) 3421 Chestnut Ave

15 Filed.....19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

(Coroner)

10/15, 1927 (Address) 5632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden — Date of Burial: Oct 17 1927

20 UNDERTAKER: C Hanson Tilson — ADDRESS: 3615 Chestnut

OCT 17 1927 G. HAMPSON JONES, M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 26505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 26505

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Claudeun ST. 13-54 WARD)

2-FULL NAME Fannie E. Booze

(a) RESIDENCE NO. 1202 Claudeun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Marshall Booze

6 DATE OF BIRTH (month, day, and year) April 2nd 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) House Keeping

(c) Name of employer Homes

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Jno. Booze

(Address) 1388 Woodyear

15 Filed OCT 17 1927 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 15th 1927, to Oct 13th 1927, that I last saw her alive on Oct 13th 1927, and that death occurred, on the date stated above, at 9:20 a m.

The CAUSE OF DEATH* was as follows:

Nephritis & Valvular Heart Disease

Near (duration) ~ yrs. 3 mos 28 ds.

CONTRIBUTORY (Secondary) Heart Disease (duration) ~ yrs. 3 mos. ~ ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? None except Urinalysis

(Signed) A. B. Glascock M. D.

, 19 (Address) 1802 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery — DATE OF BURIAL Oct 17 1927

20 UNDERTAKER Thomas E Kelson — ADDRESS 1303 Pennsylvania Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26506

CERTIFICATE OF DEATH. 1855

E 26506

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 Ga. Ave. Hosp. St. 24 Ward 24)

REGISTERED NO.

(If death occurred in a hospital or institution, give NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Cassady

(a) RESIDENCE NO. 114 E. Barney St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 26 1855

7 AGE: Years 58 Months 9 Days 12 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto. Dry Dock Co.

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Thos. J. Cassady

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Anna Weinbrenner

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Albert J. Cassady

(Address) 114 E. Barney St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

OCT 17 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct. 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of skull about 3 hrs (accidental)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fall down hatchway

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Oct. 14 1927 (Address) 257 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery Date of Burial 10/17 1927

20 UNDERTAKER: C. J. Fanning & Son ADDRESS 1460 Battery Ave.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26507 (1-PLACE OF DEATH)

101-001

E 26507 REGISTERED NO.

City of BALTIMORE: (No. 1421 W Mulberry 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Henry Palmer

(a) RESIDENCE NO. 1421 W Mulberry Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen Palmer

6 DATE OF BIRTH (month, day, and year): 3-1-1879

7 AGE: Years 48 | Months 7 | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Laundry

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country)

PARENTS

10 NAME OF FATHER: Henry Palmer

11 BIRTHPLACE OF FATHER (city or town): Balto.

(State or country)

12 MAIDEN NAME OF MOTHER: Anna Chandler

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

14 Informant: Andrew Palmer

(Address) 1421 W. Mulberry St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-13 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/12 1927 to 10/13 1927, that I last saw him alive on 10/13 1927, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C E Carrion, M. D.

10/14 1927 (Address) 1 E Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial: Oct 17 1927

20 UNDERTAKER: John H. Soudmeier — ADDRESS 1027 Hanover

C. HAMPSON HUNTER, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26508

CERTIFICATE OF DEATH.

66 E 26508

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1312 E. Monument St St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Northington

(a) RESIDENCE NO. 1312 E. Monument St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Northington

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Eastern Rolling Mills

9 BIRTHPLACE (city or town)

(State or country) Brunswick Co., Va.

PARENTS

10 NAME OF FATHER Richard Northington

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Evelyn Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Mary Northington

(Address) 1312 E. Monument

15 Filed _____ 19 _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Alcoholism

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.
(Coroner)

10/15/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brunswick Co Va. Date of Burial Oct 17 1927

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1925 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state NAME OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 1 1 1927 C. HAMPSON PM

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26509

CERTIFICATE OF DEATH.

E 26509

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hiawatha Williams

(a) RESIDENCE NO. 607 Augusta St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-30-26

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		10 mos	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) 607 Augusta St

PARENTS

10 NAME OF FATHER Francis Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Adelia Williams

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Woods

15 Filed OCT 17 1927, 19 C. HOWARD JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 12, 1927, to Oct 15, 1927,

that I last saw h alive on Oct 15, 1927,

and that death occurred, on the date stated above, at 3 2 m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. 2 mos 0 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Oct 17 1927
20 UNDERTAKER Mrs R. A. Elliott	ADDRESS 725 Asquith

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26510 ×66 E 26510

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (Ward) Stone Memorial Hospital St. 25-4

2-FULL NAME Richard Holman

(a) RESIDENCE NO. 2706 Rose St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/6/97

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or.....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) S. C

PARENTS

10 NAME OF FATHER C. Holman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S. C

12 MAIDEN NAME OF MOTHER Sallie Holman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S. C.

14 Informant Fosty Holman

(Address) 2706 Rose St

15 Filed OCT 7 1927 16 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows: Acute Dilatation Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Thos Mossman M. D.

(Coroner)

10/3, 1927 (Address) 763 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. Date of Burial Oct 7 1927

20 UNDERTAKER Mrs. H. C. Elliott ADDRESS 1225 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 26511

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26511

CERTIFICATE OF DEATH.

1135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 E. Monument ST. 58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R. Tucker Jr.

(a) RESIDENCE NO. 1003 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Sgle.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-1-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James R. Tucker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Luverne Casey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant James R. Tucker
(Address) 1003 E. Monument.

15 Filed OCT 17 1927, 19 — HAMPSON JONES, M. — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16- 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-13-, 1927, to 10-16-, 1927, that I last saw h alive on 10-15-, 1927 and that death occurred, on the date stated above, at 3 A. m

The CAUSE OF DEATH* was as follows:

Entero-colitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P. H. Gargin, M. D.

10-17-1927 (Address) 611 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Nat. Cathedral — DATE OF BURIAL Oct. 17 1927

20 UNDERTAKER Wm. R. G. Elliott — ADDRESS 1725 Eastlake

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

20 E 26532 **E 26512** HEALTH DEPARTMENT—CITY OF BALTIMORE **E 26512**

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 76-23 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Norman

(a) RESIDENCE NO. 814 N. Carey ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5-26-27

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5 4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Old

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Prentiss Norman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Blackwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Records

15 Filed OCT 17 1927 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1927, to Oct. 16, 1927, that I last saw h[illegible] alive on Oct. 16, 1927, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia

Pneumonia ?

(duration) ..... yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? ..... Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) H. C. Jones M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Oct 17, 1927
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 322 W. Schroeder St

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26513

HEALTH DEPARTMENT—CITY OF BALTIMORE E 26513

CERTIFICATE OF DEATH.

1792

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2328 E. Biddle ST., 8-16 WARD)

2-FULL NAME Mary E. Greeley

(a) RESIDENCE No. 2328 E. Biddle ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph B.

6 DATE OF BIRTH (month, day, and year) Jan. 18 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Patrick McSherry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Eliz. Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Boig
(Address) 2328 E. Biddle St

15 Filed OCT 17 1927, 19 C. HAMPSON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-1, 1927, to 10/16, 1927, that I last saw h[e] alive on 10/16, 1927, and that death occurred, on the date stated above, at 12.10 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 9 mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Fuller, M. D.

10/18, 1927 (Address) 1500 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery — DATE OF BURIAL Oct 19 1927

20 UNDERTAKER George W Snider — ADDRESS 1737 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26514 (1291)

E 26514 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Josephs Hospital St., 9-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick McDermott

(a) RESIDENCE NO. 612 E 30 St. Ward

(Usual place of abode)

Length of residence In city or town where death occurred 59 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late May. McDermott

6 DATE OF BIRTH (month, day, and year) Dec 5 1860

7 AGE: Years 66 Months 10 Days 10 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Edward McDermott

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER May. Ellen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Carroll McDermott (Address) 612 E 30th St

15 Filed OCT 17 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-15 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1927, to Oct 15, 1927, that I last saw h[illegible] alive on Oct 15, 1927, and that death occurred, on the date stated above, at 7 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Cardiac Hemiplegia

(duration) yrs. mos. 17 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. P. Thompson, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New cathedral Cemetery Date of Burial Oct. 18 1927

20 UNDERTAKER: Geo. L. Pritt ADDRESS 1735 Harford Ave

OCT 17 1927 C. HAMPSON M.D. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26515

CERTIFICATE OF DEATH.

129

E 26515

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Gibbons Ave. St. 27-44 WARD)

2-FULL NAME Jerome Norwood

(a) RESIDENCE No. 2 Gibbons Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia M. Norwood

6 DATE OF BIRTH (month, day, and year) Jan. 24-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59 yr.	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jerome Norwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant wife same address

15 Filed OCT 17 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1927, to Oct 14, 1927, that I last saw him alive on Oct. 13, 1927 and that death occurred, on the date stated above, at 9.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

acute Uremia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy Prostate Gland

Urinary Retention (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? yes Date of May 26-1927

Was there an autopsy? no.

What test confirmed diagnosis? Cystoscopy, Lab. analysis

(Signed) Martin L. Wood, M. D.

10.14 1927 (Address) 517 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 10/18 1927

UNDERTAKER George J. Ruth

ADDRESS 1750 Harford Ave

OCT 17 1927 C. HAMPSON JONES, M. D.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 26516

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26516

CERTIFICATE OF DEATH.

43

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Rappolt

(a) RESIDENCE NO. 2030 Eastern Ave St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara L. Rappolt

6 DATE OF BIRTH (month, day, and year) Nov 22/1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) Southern Soda

(c) Name of employer Fountain Co

9 BIRTHPLACE (city or town) ____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Herman Rappolt

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Germany

14 Informant Mrs. Clara L. Rappolt

(Address) 2030 Eastern Ave

15 Filed ____, 19__ Registrar

OCT 17 1927 C. HAMPSON

Per ____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-hemorrhage, carcinoma tonsil

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) ____

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. J. Kaufman, M. D.

(Coroner)

10-17-27 (Address) 508 E. Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the state ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — Date of Burial 10/19 192?

20 UNDERTAKER Johns Hopkins — ADDRESS 3300 Eastern Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS

Sp[illegible]-7-1[illegible] Co. [illegible] Bks.

E 26517

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26517

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvina Hoskins

(a) RESIDENCE NO. 502 N. Vincent St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 1878

7 AGE: Years 49 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Cambridge

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) "

(State or country)

12 MAIDEN NAME OF MOTHER Harriet Hanley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Emma Pratt

(Address) Cambridge Md.

15 Filed OCT 17 1927 19

C. HAMPTON JONES

Per

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14 1927, to Oct 15 1927, that I last saw h[illegible] alive on Oct. 15 1927, and that death occurred, on the date stated above, at 5 00 P m.

The CAUSE OF DEATH was as follows:

Cardiac decompensation

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile changes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) John W. Sause M. D.

(Address) Provident Hosp

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md

Date of Burial: Oct 17 1927

20 UNDERTAKER: Samuel Stanley

ADDRESS: Cambridge Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Blks.

E 26518

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 26518

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 634 Mosher St 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Alexander Robinson

(a) RESIDENCE NO. 634 Mosher St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1905

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	22 yrs	3	15 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General natura of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Stanley Robinson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Estelle Harding

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs. Bessie Campbell Cousin

(Address) 634 Mosher St.

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 13, 1927

that I last saw h~~im~~ alive on October 13, 1927

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Ac. Parenchymatous nephritis 6 wks

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ? yrs. mos 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. P. Naughton M. D.

10/15, 1927 (Address) 825 N. Fremont Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial 10-17 1927

20 UNDERTAKER Samuel Hemsley & Bro. ADDRESS 578 W Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 26519

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26519

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 Bruce ST. 17th WARD)

2-FULL NAME Lucy Johnson

(a) RESIDENCE NO. 522 Bruce ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 20, 1863

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
64	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Alex. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Agnes Lonell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Agnes Harris

(Address) 522 Bruce St.

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1927, to Oct 15, 1927, that I last saw her alive on Oct 4, 1927 and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. Cond.

(Signed) Dan'l Raynard M. D.

Oct 16 1927 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL Oct 17 1927

20 UNDERTAKER Emmett Linthicum & Riddle ADDRESS 576

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26520

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26520

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 21 East Woodland ST. 47-56 (WARD)

2-FULL NAME David A. Geller

(a) RESIDENCE No. 21 East Woodland ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary Geller

6 DATE OF BIRTH (month, day, and year) May 1 1854

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
73	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Upholster

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Peter Geller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Geller

(Address): 21 E Woodland Ave

15 Filed . 19 . P. M. Registrar

OCT 17 1927 C. HAMPTON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 5, 1927, to Oct 15, 1927, that I last saw him alive on Oct 15, 1927, and that death occurred, on the date stated above, at 12:10 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis ?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allen D Bebee, M. D.

, 19 (Address) 4154 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 10/18/1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

207507 E 26521 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26521

CERTIFICATE OF DEATH.

K135

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morgan Warren.

(a) RESIDENCE No. 20 Main St ST., Berlin Md WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) Nov 18 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	76	~	11	~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Warren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant ..... JOHNS HOPKINS HOSPITAL

(Address) Records

15 Filed ....., 19 .....

OCT 17 1927 C. HAMPSON JONES, Registrar

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1927, to Oct. 16, 1927, that I last saw h alive on Oct. 16, 1927, and that death occurred, on the date stated above, at 2.55 P.m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy.

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pyelonephritis; Uraemia.

(duration) ..... yrs. ..... mos. ? ds.

18 Where was disease contracted if not at place of death? Berlin, Md.

Did an operation precede death? No. Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) ..... M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Berlin, Worcester Co

DATE OF BURIAL Oct 17 1927

20 UNDERTAKER W. E. Cook

ADDRESS 532 E Monument

Blanks should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 26522

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26522

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

City of BALTIMORE: (No. 1717 E. Balt St. 2-4 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dolores Gobowski

(a) RESIDENCE NO. 1717 E. Balt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7-1927.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	—	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER William Golubowski

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Soltysiak

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Mrs. Anna Golubowski

(Address) 1717 E. Lombard St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Gastro Enteritis

(Duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) 0 yrs. mos. 1 ds.

(Signed) A. C. Gehr M. D.

(Coroner)

(Address) 1743 E. Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. Date of Burial Oct. 17. 1927.

20 UNDERTAKER M. J. Sadowski ADDRESS 705 S. Ann St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 26523 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26523

CERTIFICATE OF DEATH.

14-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 811 Madison Ave St. 11-2 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Clotilde Bourbon.

(Residence in Baltimore: No. 811 Madison Ave ~~St.~~ yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, February 6th, 1847
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
70 yrs. 8 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer). Self-employed

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Leland Bourbon

11-BIRTHPLACE OF FATHER (State or Country). France

12-MAIDEN NAME OF MOTHER Mary Madigan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. Bourbon

(Address) 1200 Hanwood Ave

15-

Filed ....., 191.... C. HAMPSON JONES, M. D.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 16th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or enquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Kidneys

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) yrs. mos. ds.

(Signed) C. H. Hemmeter M. D.
(Coroner.)

Oct 16, 1917 (Address) 757 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem	Oct 19, 1917
20-UNDERTAKER	ADDRESS
Kelly & Jenkins Undertakers	1300 Eutaw St

OCT 17 1917

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

E 26524 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 74-001 **E 26524**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 212 N. Fulton Ave St. 20-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora E. Ruth

(a) RESIDENCE NO. 212 N. Fulton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Born should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel H. Ruth

6 DATE OF BIRTH (month, day, and year) May 14 1852

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	74	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mansfield

(State or country) Ohio

PARENTS

10 NAME OF FATHER John R. Heldaman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Alexander M. Meredith

(Address) 2101 N Fulton ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1927, to Oct 16 1927, that I last saw her alive on Oct 15 1927, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy) (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Donnell, M. D.

10/16 1927 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	Oct 18 1927
20 UNDERTAKER	**ADDRESS**
Chas. G. Black	742 W North ave

OCT 17 1927 C. HAMPSON JONES, Registrar

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26525 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26525

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 716 Portland St. 22-30 Ward)

Registered No.

2-FULL NAME Victoria Waitekunas

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 716 Portland St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 10/16/27.

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 3 hrs. or 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. Karol Waitekunas

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Lithuania

12-MAIDEN NAME OF MOTHER. Mary Stepanite

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Lithuania

14- (Informant) Karol Waitekunas

(Address) 716 Portland St.

15- Filed ..... 192 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10/16/27

17- I HEREBY CERTIFY, That I attended deceased from 10/16, 1927, to 10/16, 1927, that I last saw h[illegible]alive on 10/16, 1927, and that death occurred, on the date stated above, at 11.28 a.m.

The CAUSE OF DEATH* was as follows:

Prematurely

.....(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....

(Secondary)

.....(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) John T. Hebbeler, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer DATE OF BURIAL, 10/17/27

UNDERTAKER Edward F. Kruhmanbas ADDRESS 637 S. Regester

OCT 17 1927 C. HAMPSON JONES, M.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26526 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26526

CERTIFICATE OF DEATH.

× 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 26-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Drury

(a) RESIDENCE NO. East Port, Md. ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph A. Drury

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. H. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1927, to Oct. 15, 1927, that I last saw her alive on Oct. 15, 1927, and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Tuberculosis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) L. E. Madeira M. D.

10-16 1928 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md — DATE OF BURIAL Oct 18 1927

20 UNDERTAKER Jas. S. Taylor & Son — ADDRESS Annapolis Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26527

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26527

CERTIFICATE OF DEATH

129

1-PLACE OF DEATH

REGISTERED NO. 26-37

City of BALTIMORE: (No. 708 S. Sixth St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Dorn

(a) RESIDENCE NO. 708 S. Sixth St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Conrad Dorn

6 DATE OF BIRTH (month, day, and year) April 27 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	70	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Bernard Tritsch

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Katharine Reynolds (daughter)

(Address) 1155 N. Eutaw St.

15 Filed ..... 19 .....

Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/1/27, 19..., to 10/15, 1927, that I last saw h.. alive on 10/15, 1927, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis, Myocarditis Chronic interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. H. McConnell, M. D.

10/17 1927 (Address) 633-S-3-d

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Sacred Heart & Emsby	Oct 18 1927

20 UNDERTAKER Lilly & Zeller

ADDRESS 403 S. Wolfe St

OCT 17 1927 C. HAMPSON JONES, M.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 26528

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26528

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. BALTIMORE CITY HOS St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Whitelee

(a) RESIDENCE NO. 920 S. Sumerad St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Bennett

11 BIRTHPLACE OF FATHER (City or town) _____

(State or country) Wales

12 MAIDEN NAME OF MOTHER Anna Whitelee

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md.

14 Informant _____

(Address) 920 S. Sumerad

15 Filed OCT 17 1927 19 _____ Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 19 27

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1926, to Oct. 11, 1927

that I last saw her alive on Oct. 11, 1927

and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic Interstitial nephritis general and cerebral Emphysema.

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY _____

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms.

(Signed) C. Wilmer Brown M. D.

, 19 (Address) BALTIMORE CITY HOS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Sacred Heart	10/17 1927
20 UNDERTAKER	**ADDRESS**
J J Fahey Son	1315 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26529 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 38 E 26529

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals (C.H.) ST., 6-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Johnson

(a) RESIDENCE NO. 17 N. Caroline st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriett Johnson

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Alexander Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) C. HAMPSON JONES, M. D.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 4 . 19 27 , to Oct. 13 . 19 27 , that I last saw h in alive on Oct. 13 , 19 27 and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. E. Muldoon, M. D.

10-14-27 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Oct 17. 1927.

20 UNDERTAKER Kendall & Sons — ADDRESS 311 S Eden St

CAUSE OF DEATH to be properly classified. Exact statement of ONLY A. TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Rebhan

6 E 26530

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 V E 26530

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS S. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rebhan.

(a) RESIDENCE NO. 130 S. Durham St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Rebhan

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 22 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Wm. Shipley

11 BIRTHPLACE OF FATHER (City or town): Balto.

(State or country): Md.

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: Friends

(Address)

15 Filed ..... 19 ..... Registrar

BALTIMORE CITY HOSPITALS

OCT 17 1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/12/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1922 to Oct. 12, 1927.

that I last saw her alive on Oct. 12, 1927

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Syphilitic aneurism of Ascending Arch.

Pyelitis.

..... (duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY Bronchopneumonia

(Secondary)

..... (duration) ..... yrs. ..... mos. 1 wk ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Gen. Paresis

(Signed) C. Holmes Boyd, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden Date of Burial Oct 15, 1927.

20 UNDERTAKER: Wendell Mupp ADDRESS 311 Colend

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

E 26531

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26531

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mun Hospital 4-30 (ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Jo Howard~~ Arthur Tillman

(a) RESIDENCE NO. ~~Municipal~~ 404 New St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Sgl N.K.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
34	25	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ~~Laborer~~ N.K.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer N.K.

9 BIRTHPLACE (city or town) Balt.
(State or country) ~~Md.~~ N.K.

PARENTS

10 NAME OF FATHER N.K.

11 BIRTHPLACE OF FATHER (city or town) N.K.
(State or country)

12 MAIDEN NAME OF MOTHER N.K.

13 BIRTHPLACE OF MOTHER (city or town) N.K.
(State or country)

14 Informant Western Dist Police Station
(Address) Pine St.

15 Filed 1927 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1a Alcoholism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

(Signed) C. Hampson Jones, M. D.

(Coroner)

Oct 14 1927 (Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 11-8-27 192

20 UNDERTAKER Daniel Easton

ADDRESS 916 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26532

CERTIFICATE OF DEATH.

161-09

E 26532

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 919 Boyd St. 18-29 Ward)

2-FULL NAME Infant Bales

(a) RESIDENCE NO. 919 Boyd St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | IF LESS than 1 day ..... hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER William Bales

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Va

12 MAIDEN NAME OF MOTHER Hattie Barnes

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Md.

14 Informant .....

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/15 19 27

17

I HEREBY CERTIFY, That I attended deceased from 10/15 19 27 to 10/15 19 27,

that I last saw h.. alive on 10/15 19 27,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows: Premature birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

10/16 19 27 (Address) 5 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND. C. HAMPSON, Journ. M. D. Registrar of Vital Statistics. OCT 17 1927

1895 APR 13

Spec.—7-17-26—A Co.—200 Bks.

E 26533

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26533

CERTIFICATE OF DEATH

100-027

REGISTERED NO. 25-7

1-PLACE OF DEATH

City of BALTIMORE: (No. 333 Patapsco Ave St. 25-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Henry Payne.

(a) RESIDENCE NO. 333 Patapsco Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced (write the word): S Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 10, 1927

7 AGE — Years: — Months: 3 Days: 6 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER Nathaniel Payne

11 BIRTHPLACE OF FATHER (City or town): Mass.

(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Hutchins

13 BIRTHPLACE OF MOTHER (city or town): City

(State or country)

14 Informant Mary Payne

(Address) 333 Patapsco ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15/27 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1927, to Oct 15, 1927, that I last saw him alive on Oct 15 1927, and that death occurred, on the date stated above, at 6:0 p m.

The CAUSE OF DEATH* was as follows:

Lob. Bronchitis

(duration) — yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What tests confirmed diagnosis? By Ex

Oct 16, 1927 (Signed) W C Yates, M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — Date of Burial: Oct. 18 1927

20 UNDERTAKER: John J. Moran — ADDRESS 3600 E Balto St.

Oct 17 1927

APPROVED

Fill should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26534

CERTIFICATE OF DEATH.

31 V E 26534

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 409 E 22nd St. Ward) 12-50

2-FULL NAME Bernadette Dorothy Smith

(a) RESIDENCE NO. 409 E. 22nd St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): March 6 1899

7 AGE: Years 28 — Months 7 Days 10 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Godfrey A Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Hamman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Margaret Hamman Smith

(Address) 409 E. 22nd St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from October, 19 27, to October 16, 19 27; that I last saw h.. alive on October 16, 19 27 and that death occurred, on the date stated above, at 4.15 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 6 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Thomas H Slack M. D.

19 (Address) 532 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial 19

20 UNDERTAKER: Mary M Wedefield ADDRESS: 501 E 22nd

OCT 17 1927 C. HAMPSON JONES, M. D. Registrar

Dat

AMd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26535 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26535

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 701 E 21st St. 9-18 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E Dauenhauer

(a) RESIDENCE No. 701 E. 21st St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): July-10-1870

7 AGE: Years 57 Months 3 Days 5 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer): Shoe business

(c) Name of employer: M. Hyman

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Louis Dauenhauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Mangan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Rev. Frank Dauenhauer

(Address) 701 E 21st St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 15 1927

17 I HEREBY CERTIFY, That I attended deceased from October-14, 1927, to October-15, 1927, that I last saw her alive on October-15, 1927, and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

Heart Failure

Arteriosclerosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) William H. Schwartz, M. D.

10/15, 1927 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 18 1927

20 UNDERTAKER: Randall Dyffel & Son — ADDRESS: 978 N

J. HAMPSON JONES, M. D.

TION is very important. See instructions on back of certificates.

Spec.—1-12-26—M&T—500 Bks.

E 26536 HEALTH DEPARTMENT—CITY OF BALTIMORE

V Adams,

CERTIFICATE OF DEATH.

E 26536

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 141 E West. St.) (9333 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora M. Weinbrenner

(a) RESIDENCE NO. 141 E West. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Weinbrenner

6 DATE OF BIRTH (month, day, and year) Sept. 5—1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Dennis Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wooten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George H. Weinbrenner

(Address) 141 E West St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 — 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 27, 19..., to Oct 14 27, 19..., that I last saw him alive on Oct 14 27, 19..., and that death occurred, on the date stated above, at 9 55 P m

The CAUSE OF DEATH* was as follows:

Hemiplegia Cerebral

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) High blood Pressure Arteriosclerosis

(duration) yrs. 10 mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry B Kolb, M. D.

Oct. 15 1927 (Address) 1703 Eight

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodsboro Md. DATE OF BURIAL Oct 18 1927

20 UNDERTAKER E & J B Hale ADDRESS 115 E West

IF NOT PROPERLY FILLED IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26537

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26537

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Bernard Turner

(a) RESIDENCE No. 916 Shiller Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-29-26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	6	17	

17 Months

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

PARENTS

9 BIRTHPLACE (city or town) Baby Boy
(State or country) Maryland

10 NAME OF FATHER James Turner

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary Harrison

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) North Carolina

14 Informant JOHNS HOPKINS HOSPITAL
(Address) City

15 Filed ..... 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1927, to Oct. 16, 1927, that I last saw him alive on Oct 16, 1927, and that death occurred, on the date stated above, at 11:35 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia + meningitis

(duration) ..... yrs. ..... mos 17 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) ..... yrs. 1½ mos. 17 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Exam. spinal fluid

(Signed) Alan Blaxon, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL Oct 18 1927

20 UNDERTAKER David Easton ADDRESS 916 Shiller

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26538 — CERTIFICATE OF DEATH. — E 26538

1-PLACE OF DEATH Franklin Square Hosp. — REGISTERED NO. 38

CITY OF BALTIMORE: (No. Franklin & Eutaw ST. W-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Robinson

(a) RESIDENCE NO. 313 N. Eutaw ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year): June 30, 1921

7 AGE — Years: — Months: 3 Days: 16 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Thomas Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Kathleen Currie

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Thomas Robinson
(Address): 313 N. Eutaw St

15 Filed , 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1927, to Oct 16, 1927, that I last saw her alive on Oct 16, 1927, and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. 3 mos. 16 ds.

CONTRIBUTORY (Secondary): marasmus

(duration) yrs. 3 mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Wass + + + +

(Signed) Elizabeth B Sherman M. D.

, 19 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon — DATE OF BURIAL: Oct 18 1927

20 UNDERTAKER: Daniel Easton — ADDRESS: Towson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

#207416

E 26539 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26539

CERTIFICATE OF DEATH.

32

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 1-24 St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Crosby

(a) RESIDENCE NO. 427 Tyson St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3-5-27

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Jordan Crosby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Pearl Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Johns Hopkins Hospital (Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 19 27

17

I HEREBY CERTIFY, That I attended deceased from Oct. 10, 19 27, to Oct. 15, 19 27, that I last saw h alive on Oct. 15, 19 27, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows;

Tuberculous Meningitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted at Home if not at place of death?

Did an operation precede death? Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. C. Goodwin, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL Oct 16 27

20 UNDERTAKER Howard Easton ADDRESS 916 Eutaw

IMPORTANT. See instructions on back of certificates.

1927 C. HAMPSON JONES, M. D.

Cor.—12-9-25—A.C.—

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26540

CERTIFICATE OF DEATH

1927 E 26540

REGISTERED NO.

1-PLACE OF DEATH City Hospital ~~Penn Hospital~~ 16 Ward)

City of BALTIMORE: (No.

2-FULL NAME John Chavis

(a) RESIDENCE NO. 226 N Fremont St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE: Years 39 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: 0

9 BIRTHPLACE (city or town)

(State or country): N.C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: John Browne

(Address): 610 Browne St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4 1927

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Gun Shot wound.

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) 0 yrs. 1 mos. 1 ds.

Oct 16 (Signed) J C Wades M. D.

(Coroner)

19 (Address) 1436 Biray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elizabeth Bel N.C. Date of Burial: Oct 17/27

20 UNDERTAKER: Daniel Easton ADDRESS: Penn

Spec. -7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26541

90 E 26541

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brinkley

(a) RESIDENCE NO. 325 W. Hoffman St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE Years 30 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Robt O Brinkley

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Viola Rhodes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Robert O Brinkley

(Address) 322 W Hoffman St

15 Filed ... 19 ... Registrar

C. HAMPSON JONES, M. D.

1/7 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/17/27

17 I HEREBY CERTIFY, That I attended deceased from 10/16/27, 19..., to 10/17/27, 19..., that I last saw her alive on 10/17/27, 19..., and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Disease

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Renal Disease

(duration) yrs. 4 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J & W Husband, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dundas, Va. Date of Burial: Oct 18 1927

20 UNDERTAKER: Daniel Easton? ADDRESS 916 Pa ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26542 E 26542

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2018 W North Ave ST. (WARD) 15

2-FULL NAME Mary Ely

(a) RESIDENCE NO. 2018 W North Ave ST. WARD 15

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? 65 yrs. 7 mos. 20 ds.

(If non-resident give city or town and State) Resident

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (Write the word) Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb.-26-1862

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
65	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools

(c) Name of employer City of Balto.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William T. Ely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Maria Meade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Kate L. Ely (Sister in Law)

(Address) 2018 W North Ave.

15 Filed , 19 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 14th, 1927, to Oct 16th, 1927, that I last saw h[illegible] alive on Oct 16th, 1927, and that death occurred, on the date stated above, at 3 20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. Abt 3 hours mos ds

CONTRIBUTORY (Secondary) Bad Bron Study

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) , M. D.

, 19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Oct 18 1927

20 UNDERTAKER Stewart & Tomalo ADDRESS Balto Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26543

CERTIFICATE OF DEATH.

113

E 26543

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1407 Bank ST. 3-4 WARD)

2-FULL NAME Rita Gennie Patti.

(a) RESIDENCE NO. 1407 Bank ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 23/27

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
		3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Joseph Patti

11 BIRTHPLACE OF FATHER (city or town) Campobasso (State or country) Italy

12 MAIDEN NAME OF MOTHER Johnina Sparagueda

13 BIRTHPLACE OF MOTHER (city or town) Campobasso (State or country) Italy

14

Informant Joseph Patti

(Address) 1407 Bank St

15

Filed ..... 19 ..... Registrar

OCT 18 1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 14, 1927, to Oct 16, 1927, that I last saw he alive on Oct 16, 1927 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Asthma

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Enteritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Andrew L. Natalicio M.D.

Oct 17 27 (Address) 1038 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Rodeemer — DATE OF BURIAL Oct 18 27

20 UNDERTAKER Medical Hospital — ADDRESS 811 N Eutaw

THIS IS very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26544

CERTIFICATE OF DEATH.

E 26544

REGISTERED NO. 185

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. General Hosp. St. 25-27 Ward)

(If death occurred In a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Chojnowski

(a) RESIDENCE NO. 912 Pennington Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 6 1908

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	19		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Burner

(b) General nature of industry, business, or establishment in which employed (or employer) Union Ship yard

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Walter Chojnowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Salomeja Laszczk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Walter Chojnowski

(Address) 912 Pennington Ave

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

Same occurring while at work

(Duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 1 ds.

(Signed) C. E. Hodges M. D.

(Coroner)

17/27, 19 (Address) 1437 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Brooklyn Date of Burial Oct 19 1927

20 UNDERTAKER John M Weber ADDRESS 1513 Bond St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26545

CERTIFICATE OF DEATH.

E 26545

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 435 Bloom St. 14-20 Ward)

2-FULL NAME Georgie Brown

(a) RESIDENCE NO. 435 Bloom St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Oscar Brown

6 DATE OF BIRTH (month, day, and year) April 15, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Culpepper Co Va

PARENTS

10 NAME OF FATHER George Fitzhugh

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Adeline Carter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Oscar Brown.

(Address) 435 Bloom St

15 Filed ....., 19.....

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) No other cause

(duration) yrs. mos. ds.

(Signed) J. T. Kenney M. D.

(Coroner)

Oct. 17 27 Address 2572 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brandy St Va Date of Burial Oct 18 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 1303 Presstman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26546 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26546

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount St., 6-4 WARD)

REGISTERED NO. 45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carlos R Armstrong

(a) RESIDENCE NO. Jacksonville Fla ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Verla R. Armstrong

6 DATE OF BIRTH (month, day, and year) July 21, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Jacksonville

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Verla Ray Armstrong (Address) Jacksonville, Fla.

15 Filed Oct 18, 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 17, 1927, that I last saw him alive on Oct 17, 1927 and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Colon (Sphincter ferinei)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 12 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Georges Sisler, M. D.

, 19 (Address) Church Home Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jacksonville Fla — DATE OF BURIAL Oct 18 1927

20 UNDERTAKER Hughes & Jones Inc — ADDRESS 1 P Blvd

IMPORTANT—See instructions on back of certificates.

Cor.—12-9-25—A Co.--200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26547

CERTIFICATE OF DEATH.

10-001

E 26547

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 16-22 Ward)

2-FULL NAME Kenneth Collins Mackel (Brooks)

(a) RESIDENCE NO. 604 N. Mount St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	col	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12-21

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	6		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Earl Collins

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Edna Mackel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Hopkins Hospital

(Address)

15 Filed_____, 19_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Oct 16/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Autopsy at Hopkins)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (right)

(duration) .....yrs. .....mos. .....ds.

(Signed) [signature] M. D.

(Coroner)

10-17-27 19 (Address) 508 E. Northave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Date of Burial Oct 18 1927

20 UNDERTAKER Wm H Chase Inc ADDRESS 600 Mosher

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

17 1927 C. HAMPSON JONES, M. D.

Spec.—12-9 25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26548

CERTIFICATE OF DEATH.

161-001 E 26548

1-PLACE OF DEATH

City of BALTIMORE: (No. 57 S. Hilton St. 20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Stromberg

(a) RESIDENCE NO. 57 S Hilton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17 '27

7 AGE | Years | Months | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Stromberg

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bath

12 MAIDEN NAME OF MOTHER Louise Preuss

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bath

14 Informant Louise Stromberg

(Address) 57 S. Hilton St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927, to Oct 17, 1927

that I last saw h— alive on Oct 17, 1927

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Knell, M. D.

10/17, 1927 Address 4207 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer (Catholic) Date of Burial 19

20 UNDERTAKER Frank Coulson ADDRESS Woodland

DEATH is path ways, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Bks.

✓ 26549

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26549

CERTIFICATE OF DEATH.

X 190

E 26549

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 W. Gibbons ave St. 27-44 WARD)

2-FULL NAME Benjamin South Kelly

(a) RESIDENCE NO. 101 W. Gibbons ave ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Kelly

6 DATE OF BIRTH (month, day, and year): Nov. 20. 1898

7 AGE: Years 28 Months 10 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: auto mechanic

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Belair maryland

PARENTS

10 NAME OF FATHER: R. anderson Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): maryland

12 MAIDEN NAME OF MOTHER: Mabel Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Mrs E. Elizabeth Kelly
(Address)

15 Filed ..... 19 ..... Registrar

OCT 18 1927 C. HAMPTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18 1927

17

I HEREBY CERTIFY, That I attended deceased from October 17, 19 27, to October 18 19 27.

that I last saw h im alive on October 17 19 27.

and that death occurred, on the date stated above, at 1215 a. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Grace E. Foster, M. D.

, 19 (Address) 2E Hamilton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Harford Co Md — DATE OF BURIAL: Oct 20, 1927

20 UNDERTAKER: Dean & Foster — ADDRESS: Belair Md

TION is very important. See instructions on back of certificates.

Corr. 12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26550

CERTIFICATE OF DEATH.

E 26550

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 122 Winter St. St. 23-31 Ward)

2-FULL NAME Florena Lewis.(C)

(a) RESIDENCE NO. 122 Winter St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 22, 1901

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	26	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER John Lewis.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Elizabeth Hall.(C)

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.

(State or country)

14 Informant Elizabeth Lewis.(C) mother.

(Address) 837 Leadenhall St.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

10/17/27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn St. Cem. Date of Burial 19

20 UNDERTAKER ADDRESS

Wm. Brown & Son 1611 Mt. Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Form 12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26551

CERTIFICATE OF DEATH.

182 E 26551

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Harbor Island St. 58 Ward)

2-FULL NAME Samuel Gresham

(a) RESIDENCE NO. 1406 Bay St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer) Oc

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Walker gresham

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Charlet Temple

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Dr Chas. Gresham

(Address) 1409 Jefferson St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Drowning

Duration yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Asphyxia

Duration yrs. mos. 1 ds.

Signed Oct 17 27 C. C. Yates M. D.

(Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetary

Date of Burial Oct 18 1927

20 UNDERTAKER Jos. J. H. Rochester

ADDRESS 1413 Jefferson St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—C[illegible]

CERTIFICATE OF DEATH.

40 E 26552

REGISTERED NO. 26552

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2904 Parkside Drive St. 27-45 Ward)

2-FULL NAME Robert H. Burrier

(a) RESIDENCE NO. 2304 Parkside Drive St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina M. Burrier

6 DATE OF BIRTH (month, day, and year) June 16, 1874,

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John E. Hurst Co. Balto.

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER John Burrier

11 BIRTHPLACE OF FATHER (city or town)

(State or country) France

12 MAIDEN NAME OF MOTHER Margaret Espy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

Informant Wilhelmina M. Burrier

(Address) 2304 Parkside Drive

Filed [illegible] 19[illegible] Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15-th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14 19[illegible], to October 15, 1927, that I last saw h[illegible] alive on October 15th, 1927, and that death occurred, on the date stated above, at 11 3 a.m.

The CAUSE OF DEATH* was as follows:

Valvula Heart Trouble Mitral

CONTRIBUTORY (Secondary) Neurasthenia and Gastritis (duration) yrs. 6 mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted, if not at place of death? Ford Hotel

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Tests

(Signed) D. Waldram, M. D.

, 19 (Address) 210 East Preston St.

*State the Disease Causing Death, or in deaths from V[illegible] Causes, state (1) Means and Nature of Injury, and (2) Whether A[illegible] dental, Suicidal, or Homicidal. (See reverse side for additional spa[illegible]

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Oct. 19

ADDRESS

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broad

GAINLY, WITH UNFADING INK—THIS IS A P[illegible]
ld be carefully supplied. AGE should be stated i[illegible]
TH in plain terms, so that it may be properly cla[illegible]
portant. See instructions on back of certificates.
ANS should state[illegible]
ment of OCCUPA[illegible]

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26553 — CERTIFICATE OF DEATH. — 113 E 26553

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 456 N. Fremont St., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorraine E. Glick

(a) RESIDENCE No. 456 N. Fremont St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Glick

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ethel Taylor

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant John Glick
(Address) 456 N. Fremont St.

15 Filed OCT 18 1927 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1927, to Oct 16, 1927, that I last saw h[illegible] alive on Oct 16, 1927, and that death occurred, on the date stated above, at 930 a m.

The CAUSE OF DEATH* was as follows: Gastro Enteritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A C Hasel M. D.

19 27 (Address) 1901 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Oct 17 1927

20 UNDERTAKER Wm. E. Wilhelm Sons

ADDRESS 2342 Eutaw Pl.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26554
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

129 E 26554
REGISTERED NO.

CITY OF BALTIMORE: (No. 2205 E. Chase ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Frost

(a) RESIDENCE NO. 2205 E. Chase ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? 71 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Frost

6 DATE OF BIRTH (month, day, and year) Dec. 8, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	9	10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Conrad Bittner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Wisbrun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. Frost
(Address) 107 Ridgewood Rd

15 Filed OCT 18 1927, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 17 1927

17

I HEREBY CERTIFY, That I attended deceased from January 5, 1925 to Oct. 17, 1927, that I last saw h[illegible] alive on October 17, 1927, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Chronic colitis &
Toxic Myocarditis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory tests

(Signed) Alfred Longwell M. D.

10/18, 1927 (Address) 613 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County — DATE OF BURIAL Oct 19 27

20 UNDERTAKER Chas E. Hillegeas & Sons — ADDRESS 2334 Eutaw St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26555 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26555

CERTIFICATE OF DEATH.

74-006

1-PLACE OF DEATH

City of BALTIMORE: (No. 1606 Poplar Grove St., 15-67 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris L. Smith.

(a) Residence No. 1606 Poplar Grove St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White.

5-Single, Married, Widowed or Divorced. (Write the word.) Married.

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Blanch Smith.

6-DATE OF BIRTH (month, day and year) April 28 - 1875

7-AGE. 52 yrs. 5 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher.
(b) General nature of industry, business, or establishment in which employed (or employer) 0/3
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md.

PARENTS:
10-NAME OF FATHER Morris L. Smith.
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md.
12-MAIDEN NAME OF MOTHER Mary A. Shanks.
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md.

14-Informant Austin Smith.
(Address) 1606 Poplar Grove

15-
Filed OCT 18 1927 19
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 10-17-27

17- I HEREBY CERTIFY, That I attended deceased from 10-13 1927 to 10-17 1927 that I last saw him alive on 10-17 1927 and that death occurred, on the date stated above, at 1010 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

I. H. Miller M. D.
(Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodsboro Md — DATE OF BURIAL. Oct 20th 1927

20-UNDERTAKER. Powell + Albaugh — ADDRESS Woodsboro Md

Spec.—1-12-23—M&T—500 Blks.

207257

E 26556 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-003

X E 26556

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Asher

(a) RESIDENCE NO. Sparrows Pt. Rd. (ST.) Dist. (WARD) Balto Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 4 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ... (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Asher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Estelle Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1927, to Oct 16, 1927, that I last saw h— alive on Oct 16, 1927, and that death occurred, on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows: Congenital hypertrophic pyloric stenosis

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? Congenital condition

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? The autopsy findings

(Signed) Allen Blackwell, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ebenezer M. E. Church Cemetery Chase Md

DATE OF BURIAL Oct 17 1927

20 UNDERTAKER John F Denny

ADDRESS 715 E 54 St

OCT 18 1927 C. HAMPSON JONES, M.

Spec.—1-10-21—M&T—1500 Bks.

E 26557 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26557

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Poplar Grove ST., 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Ziegfeld

(a) RESIDENCE NO. 1404 Poplar Grove ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julius Wm Ziegfeld

6 DATE OF BIRTH (month, day, and year): April 26th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
S	50	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cincinnati, Ohio.

PARENTS

10 NAME OF FATHER: Wm Raine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bavaria

14 Informant (Address): Julius Wm Ziegfeld

15 Filed ..... 19 ..... Registrar

OCT 19 1927 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to October 17, 1927, that I last saw h er alive on October 16, 1927, and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? microscopic

(Signed) Erwin F. Krueger, M. D.

10/17, 1927 (Address) The Eglenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 10/19/1927

20 UNDERTAKER: Geo. Weber & Son

ADDRESS: 2503 Edmondson Ave

NOTE IS VERY important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26558
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

89 E 26558
REGISTERED NO.

City of BALTIMORE: (No. 1723 Lemmon St. 19-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wilhelmina Rau

(a) RESIDENCE NO. 1723 Lemmon St St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX f

4 Color or Race W

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J. Rau

6 DATE OF BIRTH (month, day, and year) April (4) 1860

7 AGE — Years 67 | Months 5 | Days 14 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER John Himmler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Waldsache

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Augusta Stenkle
(Address) Dayton, 640 Raymond Ave

15 Filed 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-15-27 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 1927, to Oct 15, 1927, that I last saw h alive on Oct 15, 1927, and that death occurred, on the date stated above, at 12 M

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted —
If not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) Benj O McCleary, M. D.
10/16 1927 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Oct 18 1927

20 UNDERTAKER H. B. Pippert ADDRESS 1850 W. Baltimore

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Leipman Roos ✓

E 26559 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26559

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 146 Welkens St. 70-69 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leopoyuyn Roos

(a) RESIDENCE NO. 146 Welkens ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leopold Roos

6 DATE OF BIRTH (month, day, and year) June 30th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Roos

(Address) 146 Welkens St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1927, to Oct 17, 1927, that I last saw him alive on Oct 16, 1927, and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

10/17 1927 (Address) 108 N Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery | DATE OF BURIAL Oct 20th 1927

20 UNDERTAKER E. S. Neffelt | ADDRESS 1850 W Baltimore St

OCT 18 1927 C. HAMILTON

Dr Kinsey — 2700 Norford Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26560

CERTIFICATE OF DEATH.

E 26560

1-PLACE OF DEATH — Hamilton

CITY OF BALTIMORE: (No.) 315 Walnut Ave (St.) 47-33 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella M Wynkoop

(a) RESIDENCE NO. 315 Walnut Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): School

(c) Name of employer: Grand Rapids Mich

9 BIRTHPLACE (city or town) (State or country): Mich

PARENTS

10 NAME OF FATHER: George Wynkoop

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mich

12 MAIDEN NAME OF MOTHER: Katherine Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant: Katherine York

(Address) 315 Walnut Ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1927

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1927, to Oct 17, 1927, that I last saw her alive on Oct 15, 1927, and that death occurred, on the date stated above, at 11:50 A m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma.
original focus l. breast

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mich.

Did an operation precede death? Yes Date of 1925

Was there an autopsy? no

What test confirmed diagnosis? clinical

10 (Signed) Fritz J Kinsey, M. D.

10-17-27 19 (Address) 2700 Norford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Grand Rapids Mich

DATE OF BURIAL: Oct 18 19 27

20 UNDERTAKER: Nelson Cook

ADDRESS: 502 E Madison

OCT 18 1927

G.P.G.

Spec.—1-12-23—M&T—500 Bks.

E 26561

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO. 161-06

CITY OF BALTIMORE: (No. ..... ST., 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Cerney

(a) RESIDENCE NO. 610 E. Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or ~~Divorced, (write the word)~~: Baby

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-13-24

7 AGE: Years: 24 hours; Months: ; Days: 1; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Louis Cerney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md —

12 MAIDEN NAME OF MOTHER: Lottie Vance

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Johns Hopkins Hospital (Address) Carey

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1927, to Oct 14, 1927, that I last saw her alive on Oct 14, 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19 27

20 UNDERTAKER

ADDRESS

C. HAMPSON JONES, M. D.

Registrar

Spec.—1-10-21—M&T—1500 Bks.

E 26562

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26562

CERTIFICATE OF DEATH.

161-6

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cole

(a) RESIDENCE NO. 716 E Monument St Jnd

(Usual place of abode) ST., WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29, 1927

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

Twof 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles H. Addison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Florence Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14

Informant

(Address) Johns Hopkins Hospital

15

Filed ..., 19

1808 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1927

17

I HEREBY CERTIFY, That I attended deceased from July 29, 1927, to Oct. 12, 1927

that I last saw her alive on Oct. 12 1927

and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 2 mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C H Williams, M. D.

10-12 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

OCT 18 1927

Fill out completely. Use typewriter. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 26563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-082

E 26563

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hinton

(a) RESIDENCE NO. 731 Essex ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14, 1927

7 AGE

Years	Months	Days	If LESS than 1 day 14 hrs. or 30 min.
		one	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Moses H. Hinton

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Jackson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va.

14 Informant C. S. Williams M. D. (Address) Johns Hopkins Hospital

15 Filed Oct 18 1927 19 ..... ACH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1927, to Oct. 16, 1927, that I last saw him alive on Oct. 16, 1927, and that death occurred, on the date stated above, at 6 35 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Birth Injury)

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) C. S. Williams, M. D.

Oct 17 19 27 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL ..... 19 .....

20 UNDERTAKER ..... ADDRESS .....

JOHNS HOPKINS HOSPITAL
C. HAMPSON JONES, M. D.
Commissioner of Health
OCT 18 1927

BACK OF CERTIFICATE.—INSTRUCTIONS ON BACK OF CERTIFICATE.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26564

66 E 26564

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1124 Orleans St. St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Whittington

(a) RESIDENCE NO. 1124 Orleans St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Whittington

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: about 51 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Mrs Dora Pratt 1704 Park Pl Ave

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: George Armstrong

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Snowhill Md

12 MAIDEN NAME OF MOTHER: Elizabeth Wilson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Cambridge Md

14 Informant: Andrew Jackson

(Address): 112 Orleans St

15 Filed ....., 19 .....

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Oct 17/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Alcoholism

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Collins M. D.

(Coroner)

10-18-19 27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — Date of Burial: Oct 18 1927

20 UNDERTAKER: Charles F. Evans & Son — ADDRESS 1180 W Royal Ave

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26565

CERTIFICATE OF DEATH.

3 E 26565

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1340 N. Fremont St. Ward 20)

2-FULL NAME Margie Eppa.

(a) RESIDENCE NO. 1340 N. Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: [illegible]

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 23, 1923

7 AGE: Years 7 Months Days 24 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of Industry, business, or establishment in which employed (or employer): (Orphans)

(c) Name of employer

9 BIRTHPLACE (city or town): Balt.

(State or country)

PARENTS

10 NAME OF FATHER: Clinton Eppa

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Fannie Eppa

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Fannie Eppa

(Address) 1340 N. Fremont

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 17, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pleuro-Colitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) no other history

(duration) ..... yrs. ..... mos. 3 ds.

Signed J. T. Hennessy M. D. (Coroner)

Oct. 18, 19 27 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery Date of Burial Oct 18 19 27.

20 UNDERTAKER: Thomas E. Kelson. ADDRESS 1383 Presstman St.

Very important. See instructions on back of certificate.

OCT 18 1927 HAMPSON JONES M. D.

Spec.—1-12-23—M&T—500 Bks.

E 26566 (1/2)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26566

CERTIFICATE OF DEATH.

× 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-9 WARD)

2-FULL NAME Bernice - Gray

(a) RESIDENCE NO. Logan, W. Va ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or ~~Divorced, (write the word)~~: Child

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-5-1919

7 AGE Years: 8 Months: 5 Days: 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Charles Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va

12 MAIDEN NAME OF MOTHER Maud Rutledge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1927, to Oct 18, 1927, that I last saw him alive on Oct 18, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hypertension & chronic nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Montgomery W Va — DATE OF BURIAL: 10/18/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Biway

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26567

CERTIFICATE OF DEATH.

90 E 26567

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1326 Hollins St. 19-29 (Ward)

2-FULL NAME Nellie E. Umberger

(a) RESIDENCE NO. 1326 Hollins St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr 10 1874

7 AGE: Years 53 Months 6 Days 7 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Dennis McNeary

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine English

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. Annie McNeary

(Address) 204 E. Market St. Williamstown, Pa.

15 Filed....., 19.....

Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and Inquiry. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest and Inquiry (autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

Oct 18 1927 (Address) Curtis Bay, Balto. Md

(Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Williamstown, Pa. Date of Burial Oct. 20 1927

20 UNDERTAKER: John F. Howard & Son ADDRESS 901 Hollins St

Very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 26568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 26568

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 St. Paul Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Isabella Hoffman

(a) RESIDENCE NO. Home for the Aged of the St. M. E. Church

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Eighteen How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Heck~~

6 DATE OF BIRTH (month, day, and year) March 4- 1851

7 AGE — Years: 76 Months: 7 Days: 13 IF LESS than 1 day, hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER James Lunn.

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Interment (Address) Records of the Home for the Aged of the M. E. Church

15 Filed . 19 C. HAMPSON JONES, M. D. Registrar

OCT 19 1927 Per H.A.W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17. 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 1 . 19 27. to Oct 17 . 19 27.

that I last saw h-er alive on Oct 16 . 19 27.

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Clinical Method

(Signed) Geo. L. Shannon . M. D.

10/18 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial: Oct 19 1927

20 UNDERTAKER: George J Smith — ADDRESS: 169 Hollins

Very important. See instructions on back of certificates. PENALTY STATEMENT OF OCCUPATION IS

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 26569 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26569

CERTIFICATE OF DEATH

1-PLACE OF DEATH { 2317 W. La Fayette Ave. 90

CITY OF BALTIMORE: (No.) 16-68 (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Dimmock Smith

(a) RESIDENCE NO. 2317 W. La Fayette Ave. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie H. Smith

6 DATE OF BIRTH (month, day, and year) March 31, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Wholesale Corp.

9 BIRTHPLACE (city or town) (State or country) Richmond, Virginia

PARENTS

10 NAME OF FATHER William Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ilchester, Howard County, Maryland

12 MAIDEN NAME OF MOTHER Henriette Dimmick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va.

14 Informant (Address) Mollie H. Smith 2317 W. Lafayette Ave.

15 Filed OCT 19 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 16 1927

17 I HEREBY CERTIFY, That I attended deceased from October 11. 1927. to Oct. 16. 1927.

that I last saw h in alive on October 16. 1927.

and that death occurred, on the date stated above, at 15:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Cardio-sclerosis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) Carlos I. Baggott M. D.

19 (Address) 1015 Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton, Md. DATE OF ~~FUNERAL~~ Shipment 10/19/27 19

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Baltimore St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26570

CERTIFICATE OF DEATH.

11 E 26570

1-PLACE OF DEATH

City of BALTIMORE: (No. 1801 McHenry St. 14-28 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriet E. Walter (Walz)

(a) RESIDENCE NO. 1801 McHenry St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmale

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A Walz

6 DATE OF BIRTH (month, day, and year): Jan 16 = 1850

7 AGE: Years 77 Months 9 Days 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Phila, Pa

PARENTS

10 NAME OF FATHER Daniel W. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Bridget Mooney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Mary Fisher

(Address) 1601 E. Chase St

15 Filed_____, 19_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 18, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest or Inquiry.) thereon and from the evidence obtained [illegible] Inquest or Inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Indigestion

(duration) one hour

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D.

(Coroner)

Oct 18 1927 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See [illegible] Additional Instructions.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem Date of Burial Oct. 20 1927

20 UNDERTAKER: [illegible] Cook ADDRESS 1003 W Balto

OCT 19 1927

Spec.—1-10-21—M&T—1500 Bks.

E 26571

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calhoun ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Dyson

(a) RESIDENCE NO. Drayden, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE black

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Agnes Dyson

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE Years 44 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman - do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md -

PARENTS

10 NAME OF FATHER Steven Dyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Agnes Dyson

(Address) Drayden Md.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1927, to Oct. 18, 1927,

that I last saw him alive on Oct. 17, 1927,

and that death occurred, on the date stated above, at 12 AM m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever -

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Drayden, Md

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Widal pos

(Signed) E. B. Thornton, M. D.

, 19 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Porto Bella Md.

DATE OF BURIAL Oct. 17 1927

20 UNDERTAKER Henry Sanders Sons Inc

ADDRESS 1710 Fleet St.

1927 C. HAMPSON JONES, M. D.

Spec.—7-17-26—A Co.—200 Bks.

Joseph Worsham

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26572

CERTIFICATE OF DEATH

90

E 26572

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Worsham

(a) RESIDENCE NO. 2009 Oak Hill St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Albert D Worsham

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) ?

12 MAIDEN NAME OF MOTHER Elizabeth Barker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) ?

14 Informant

(Address) Richmond

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10/1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1927, to Oct 10, 1927, that I last saw him alive on Oct 8, 1927, and that death occurred, on the date stated above, at 2 00 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia,
Lobular

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic

Contributory (duration) yrs. 6 mos ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Sign

(Signed) C. Hamilton Bryant, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mount Carmel Cemetery	Oct. 20 1927
20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	1110 Fleet St.

Very important. See instructions on back of certificates.

OCCUPATION

OCT 19 1927 C. HAMILTON JONES, M.D.

Spec.—1-12-23—M&T—500 Bks.

E 26573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 E 26573

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 N. Bentalou ST., 16-68 WARD)

2-FULL NAME Isabella B. Clayton

(a) RESIDENCE NO. 1320 N. Bentalou ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of R. V. Clayton

6 DATE OF BIRTH (month, day, and year) Feb 3-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Rev. W. T. Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sibella Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Louisa Edwards
(Address) 926 N. Fayette

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1927, to Oct 17, 1927, that I last saw h[illegible] alive on Oct 16, 1927 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Fracture neck of femur. (Accidental) (Operation)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M B Maynard Lord, M. D.

10/19, 1927 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md — DATE OF BURIAL 10/19 1927

20 UNDERTAKER W. M. Cook — ADDRESS Sorrento

Spec.-7-17-26—A Co.—200 Bks.

E 26574

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26574

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hosp. St. 12th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Virginia Jeffs.

(a) RESIDENCE NO. Landsdown 3rd Ave St. Ward

(Usual place of abode) Baltimore Md.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 20 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): August 27-27

7 AGE — Years: 0 Months: 1 Days: 20

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Millard Jeffs.

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mildred Brown

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant: Mother (Mildred Jeffs)

(Address) Landsdown 3rd and City

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct 17-27

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1927, to Oct 17, 1927,

that I last saw her alive on Oct 17, 1927,

and that death occurred, on the date stated above, at 6 45 a.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial: Oct. 19 1927

20 UNDERTAKER: Nelson E. Stiles — ADDRESS 231 Ind. Ave Westport.

Very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26575

CERTIFICATE OF DEATH

16-002

E 26575

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hosp. St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosella Owings

(a) RESIDENCE NO. 652 W Lombard St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18/1927.

7 AGE: Years 0 Months 4 Days 0 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ND

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER William Owings

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Viola Jeffers

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mother

(Address) 652 Lombard St

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Oct 18 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1927, to Oct 18, 1927, that I last saw her alive on Oct 18, 1927, and that death occurred, on the date stated above, at 4 45 p. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. mos 5 wks 3 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos 1 ds.

18 Where was disease contracted

If not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Geraghty, M. D.

10/18, 1927 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden — Date of Burial: 10/19 19 27

20 UNDERTAKER: J Walter Davis — ADDRESS: 3307 Paine

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CITY 1927 [illegible]

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26576

E 26576

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Zimmerman

(a) RESIDENCE NO. 5403 Longwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) July 2 1852

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	75	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk for 49

(b) General nature of industry, business, or establishment in which employed (or employer) B & O Railroad

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Benjamin Franklin Zimmerman

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ann Renshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant James A. Zimmerman (Address) 5403 Longwood ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

OCT 19 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Oct 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 19 27, to Oct 17, 19 27, that I last saw h alive on Oct 17, 19 27, and that death occurred, on the date stated above, at 2 00 P.m.

The CAUSE OF DEATH* was as follows:

Probably Carcinoma of Intestines

(duration) yrs. 2 mos. 7 da.

CONTRIBUTORY (Secondary) Generalized Arteriosclerosis

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	Oct 19 1927
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North ave

Only important items need be filled in. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26577 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26577

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 W Lombard St. Ward 18-24)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry C. Rossbach

(a) RESIDENCE NO. 839 W Lombard St. WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Katie Rossbach

6 DATE OF BIRTH (month, day, and year) Oct 3-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry C. Rossbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Augusta Koldewey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Katie Rossbach
(Address) 839 W. Lombard.

15 Filed ....., 19 ..... F. C. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1927, to Oct. 17, 1927, that I last saw him alive on Oct. 17, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia.

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Acute La Grippe.

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Findings etc.

(Signed) C. Hampson Jones, M. D.

19 (Address) 839 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Oct 20 1927

20 UNDERTAKER J. D. Turner & Son

ADDRESS 1015 Hanover St

Oct 20 1927 C. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

E 26578

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26578

CERTIFICATE OF DEATH

89

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. 3424 Guilford Terrace St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kemp Hoen

(a) RESIDENCE NO. 3424 Guilford Terrace St. _____ Ward Resident

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 8 mos. 8 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 60 yrs. 8 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine R. Hoen

6 DATE OF BIRTH (month, day, and year) February-9-1867

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	60	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Fish

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest Hoen

11 BIRTHPLACE OF FATHER (City or town) Unknown

(State or country) Germany

12 MAIDEN NAME OF MOTHER Frances E. Nixdorff

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Katherine R. Hoen (wife)

(Address) 3424 Guilford Terrace

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1927 to Oct 17 1927

that I last saw h[illegible] alive on Oct 17 1927

and that death occurred, on the date stated above, at 10-20 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted Not known

if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. Pearman, M. D.

10-17, 1927 (Address) 1 East Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Greenmount Cemetery	Oct-19-27 19

20 UNDERTAKER ..... ADDRESS .....

OCT 19 1927

STEWART & MOWEN COMPANY

...W. NORTH...

...certificates. See instructions on back of cer...

Spec.—1-10-21—M&T—1500 Blks.

E 26579 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26579

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1243 Brentwood Ave ST., 25-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Virginia Bonsall,

(a) RESIDENCE NO. 1243 Brentwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, (~~HUSBAND~~) of (or) WIFE of late William H. Bonsall

6 DATE OF BIRTH (month, day, and year) Nov 4. 1866

7 AGE: Years 61 Months 11 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Connecticut.

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore.

12 MAIDEN NAME OF MOTHER Daily.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs Lillian H. Davis 2232 Edmondson Ave

15 Filed OCT 19 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 17, 1927

17

I HEREBY CERTIFY, That I attended deceased from September 22, 1927, to Present, 19 ,

that I last saw her alive on Oct. 17, 1927,

and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. Anthauser, M. D.

10/17, 1927 (Address) 1201 Fifteen Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem. DATE OF BURIAL: Oct 20 1927

20 UNDERTAKER: Jos Jacobsons Son ADDRESS: 217 S. Pa.

Spec.—1-1931—M&T—1500 Bks.

E 26580 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26580

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincents Infant Asylum St. WARD)

REGISTERED NO. 26563

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Barton

(a) RESIDENCE NO. Reisterstown Rd ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7+ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years — Months: About 8 mo. old — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Foundling

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Walter C Bacon
(Address) 1002 20th St

15 Filed OCT 19 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to Oct 17, 1927, that I last saw her alive on Oct 17, 1927 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Those of Malnutrition

(Signed) Walter C. Bacon, M. D.

10/17, 1927 (Address) 1002 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem — DATE OF BURIAL: 10/19/27

20 UNDERTAKER: John J. Foley Sons — ADDRESS: 3 Light

Spec.—1-12-23—M&T—500 Bks.

E 26581

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3E 26581

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 320 Rossiter Ave ST., 27-48 (WARD)

2-FULL NAME Margaret A. Royston

(a) RESIDENCE No. 320 Rossiter Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles R Royston

6 DATE OF BIRTH (month, day, and year): July 2 - 1857

7 AGE: Years 70 | Months 3 | Days 16 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co.

PARENTS

10 NAME OF FATHER: Henry Gregory

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co.

12 MAIDEN NAME OF MOTHER: Rachel Bowlis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co.

14 Informant: Mr. Royston

(Address) 320 Rossiter Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 2 1927, to Oct 18 1927, that I last saw her alive on Oct 16 1927, and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Nephritis (Chronic Interstitial)

(duration) — yrs. 4 mos + ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jefferson Buck, M. D.

10/18, 1927 (Address) 105 Club Road

*State the Disease Causing Death, or in deaths from Violeot Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Oct 20 1927

20 UNDERTAKER: A S Marshall — ADDRESS: 3539 Taft Road

OCT 19 1927 C. HAMPTON JONES, M. D.

Cor.—1-12-23—M&T—100 Bks.

E 26582

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26582

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebb Univ Hospital ST., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME James Scott

(a) RESIDENCE NO. Not known ST., 1541 Fryglevare WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ COLOR OR RACE: Male Colored

5 Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: N. K

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: N K
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: N K.

9 BIRTHPLACE (city or town) (State or country): N K

10 NAME OF FATHER: N. K

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. K

12 MAIDEN NAME OF MOTHER: N. K

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N K

Informant (Address): Western Dist Police Line St.

Filed OCT 10 1917 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 - 1917

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Alcoholism

Exhaustion (duration) 5 yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver (duration) yrs. mos. 1 ds.

Oct 11 1917 (Address) 143 N Bond M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem DATE OF BURIAL Oct 13 1917

20 UNDERTAKER: Samuel Stanley ADDRESS 1130 E Balto

Spec.—I-10-21—M&T—1500 Bks.

E 26583 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26583

CERTIFICATE OF DEATH.

REGISTERED NO. 160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Vincents Infant Asylum (St.) 2563 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Strong

(a) RESIDENCE NO. ... Reisterstown Rd ST. ... WARD ...
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (or) HUSBAND of (or) WIFE of: /

6 DATE OF BIRTH (month, day, and year): July 5, 1927

7 AGE: Years ... Months 3 ~~July~~ Days 9 14 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: James H. Strong

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Mary Strong

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant (Address): Walter C Bacon Balto. Md

15 Filed ... 19 ... By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 16 1927 to Oct 17 1927, that I last saw him alive on Oct 17 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Marasmus

(duration) yrs. 3 mos 14 ds.

CONTRIBUTORY (Secondary) ... (duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cause of Malnutrition

(Signed) Walter C Bacon M. D.

10/17/27 (Address) 1002 20[illegible] St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem

DATE OF BURIAL: 10/19 1927

20 UNDERTAKER: [illegible]

ADDRESS: 13[illegible] Light

OCT 19 1927 C. HAMPSON JONES, M.D.

Cor.—12-9-25—A Co.—200 Bks.

E 26584

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26584

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1st St.nr. Washington, Brooklyn. St., 25-12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J. Halligan.

(a) RESIDENCE NO. 311 S. Fourth St. Brooklyn. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 4, 1886.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Michael Halligan.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Warten.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland.

14 Informant Mrs. McGuire (sister)

(Address) 311 S. Fourth St. Brooklyn.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 18, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) and inquiry. find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull, probably due to having been struck by a hit & run Automobile

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt M. D.

(Coroner)

10/19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...d.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial: 10/19 1927

20 UNDERTAKER: Chas. J. Carey & Sons ADDRESS: 1315 Linden

OCT 19 1927 C. HAMPSON JONES, M. D.

Cor.—12-4-25—A Co.—200 Bks.

E 26585 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26585

CERTIFICATE OF DEATH.

REGISTERED NO. 16-2269

1-PLACE OF DEATH
City of BALTIMORE (No.) Boat Lake B.H. Park St. (16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Disco.

(a) RESIDENCE NO. 1026 N Mount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Disco

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER John Johnson
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md
12 MAIDEN NAME OF MOTHER Dorsey Brown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Philip Disco
(Address) 1026 N. Mount St

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Drowning

Duration ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Asphyxia

Duration ..... yrs. ..... mos. 1 ds.

Oct 17 1927 Signed G. E. Radcliffe (Coroner) M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial Oct 19 1927

20 UNDERTAKER Howard Easton ADDRESS 916 Pa ave

Spec.–7-17-26—A Co.—200 Bks.

David Ferguson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26586

38

E 26586

CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1509 Mulliken St., 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Ferguson

(a) RESIDENCE NO. 1509 Mulliken St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Davis

6 DATE OF BIRTH (month, day, and year): Dec 11 1879

7 AGE: Years 47 Months 10 Days 4

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: David Ferguson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Annie Ferguson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Annie Ferguson

(Address): 1509 Mulliken St

15 Filed _____, 19 _____ Registrar

OCT 19 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 15, 19 27, to Oct 15, 19 27, that I last saw h alive on Oct 15, 19 _____, and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Renal

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Renal

(Signed) [illegible], M. D.

10-19 1927 (Address) 1509 Mulliken St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery Date of Burial Oct 19 1927

20 UNDERTAKER: Milton. Davis ADDRESS 316 N Eden St

Spec.–7-17-26–A Co.–200 Bks.

E 26587

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26587

CERTIFICATE OF DEATH

101-001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 715 So. Durham St., 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRANK URBANOWSKI,

(a) RESIDENCE NO. 715 So. Durham St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. If of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Urbanowski,

6 DATE OF BIRTH (month, day, and year) November 1- 1870.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
56 57	11	15		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. Wiesktiel & Son,

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.

PARENTS

10 NAME OF FATHER Frank Urbanowski,

11 BIRTHPLACE OF FATHER (City or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Mrs. Dora Urbanowska, (wife)

(Address) 715 So. Durham St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 27 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 19 27 to Oct 16 19 27

that I last saw h alive on Oct 16 19 27

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilat

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

(Address) 701 Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Stanislaus.	Oct 20 1927
20 UNDERTAKER	ADDRESS
M. F. Sadoski	705 S. Linwood

OCT 19 1927

Spec.–7-17-26—A Co.—200 Bks.

E 26588 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26588

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1711 Lancaster St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME GEORGE M.FISHER,

(a) RESIDENCE NO. 1711 Lancaster St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White,	Marrier,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Fisher,

6 DATE OF BIRTH (month, day, and year) April 1--1875.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	52	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER Michael Fisher,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant Mrs. Bessie Fisher, (Wife)

(Address) 1711 Lancaster Street

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 18– 1927

17 I HEREBY CERTIFY, That I attended deceased from August 16, 1927, to Oct 18–, 1927.

that I last saw h— alive on Oct 17, 1927.

and that death occurred, on the date stated above, at 9.10 a – m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dis – Valvular

(duration) 1 yrs. – mos. – ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted ✓

if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? –

(Signed) Samuel Brezler, M. D.

, 19 (Address) 1254 Bluxy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Stanislaus	Oct 21. 1927
20 UNDERTAKER	**ADDRESS**
W J. Sadowski.	705 S. Ann

Spec.—7-17-26—A Co.—200 Bks.

E 26589

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26589

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2929 Windsor ave St. 5-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Manly

(a) RESIDENCE NO. 2929 Windsor Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stephen V. Manly Sr.

6 DATE OF BIRTH (month, day, and year): May 18-1853

7 AGE — Years: 74 — Months: 5 — Days: — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Geo. W. Hurdle

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Elizabeth Moorehead

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant (Address): Geo. Manly 2929 Windsor Ave

15 Filed ..... 19 ..... Registrar: H.A.W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 18th 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1927, to Oct 18, 1927, that I last saw h.. alive on Oct 18, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arterial Sclerosis

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary): Cirrhosis Rectum

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. H Phillips M. D.

. 19 (Address) 2300 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — Date of Burial: 10/21 1927

20 UNDERTAKER: Chas F. Traud & Son — ADDRESS: 1180 N. Paca Ave

C. HAMPSON JONES

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26590

CERTIFICATE OF DEATH.

168 E 26590

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Jail St. 10-15 Ward)

2-FULL NAME James Jake

(a) RESIDENCE NO. — St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day..... hrs. or..... min.
	34 to 39 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ?

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... ?

(State or country) Austria ?

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

Oct 18 (Signed) W. J. Reilly M. B.
(Coroner)
, 1927 (Address) 16 > 9 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. .. mos. .. ds. In the State Entire life yrs. .. mos. .. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OCT 18 1927 C. HAMPSON JONES, M. D. Commissioner of Health.

THE MORGUE.

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26591

CERTIFICATE OF DEATH

161-001 E 26591

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 N. Fremont St., 4-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Hobday Gross

(a) RESIDENCE NO. 515 N. Fremont St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10.15.1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Robt H. Gross

11 BIRTHPLACE OF FATHER (City or town) City

(State or country)

12 MAIDEN NAME OF MOTHER Augustine Hobday

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Robt H. Gross

(Address) 515 N. Fremont

15 Filed ....., 19 .....

Registrar

1813 ARK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 19 27, to Oct 18, 19 27,

that I last saw h.. alive on Oct 18, 19 27,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Prem. Premature birth

Cong / mo.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inability to feed

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas L. Hoopes, M. D.

19 (Address) 862 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

Spec.-7-17-26—A Co.—200 Bks.

E 26592

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

E 26592

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

City of BALTIMORE: (No. 33-41 Calvert St. 14-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Talbott

(a) RESIDENCE NO. Greenway Apts St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 29, 1888

7 AGE: Years 39 Months 8 Days 20 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Cincinnati, Ohio

(State or country)

PARENTS

10 NAME OF FATHER Robert N. Talbott

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Jane Hall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Kentucky

14 Informant Robert N Talbott

(Address) Greenway Apts

15 Oct 19 1927 Registrar ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1927 to Oct 19, 1927

that I last saw her alive on Oct. 19, 1927

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Abdominal adhesions

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ileus with peritonitis

(duration) yrs. mos 1½ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of Oct. 14, 27

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R O Beacock, M. D.

10 Oct 19 27 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lexington Kentucky — Date of Burial Oct 20 1927

20 UNDERTAKER: Perry Hopkins Sons — ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 26593

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26593

CERTIFICATE OF DEATH.

REGISTERED NO. 101-007

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; No. 2881 Woodbrook Ave ST. 13-54 WARD)

2-FULL NAME William J Ruppel

(a) RESIDENCE NO. 2881 Woodbrook Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lilla F Ruppel

6 DATE OF BIRTH (month, day, and year) May 7 1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
66	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Un. Rail Road

9 BIRTHPLACE (City or town) (State or country) Balto Md

10 NAME OF FATHER Anselm Ruppel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Yakel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARENTS

14 Informant Mozella Ruppel (Address) 2881 Woodbrook Ave

15 Filed . 19 NOV 17 1927 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 7 . 1927 . to Oct 17 . 1927 ,

that I last saw h alive on Oct 17 . 1927 ,

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Ledger E Flowers M. D.

, 19 (Address) 1500 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Oct 21 1927

20 UNDERTAKER H. C. Cook — ADDRESS 1500 E Hollins St

Cor.—12-9-25—A Co.—200 Bks.

E 26594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 E 26594

REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No. City Hospital St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. Johnson

(a) RESIDENCE NO. 703 S Rotmarr St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillian B Johnson

6 DATE OF BIRTH (month, day, and year): Feb 16-74

7 AGE: Years 53 Months Days. IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Own Self

9 BIRTHPLACE (city or town): Carroll Co
(State or country): Md

PARENTS

10 NAME OF FATHER: Thomas Johnson
11 BIRTHPLACE OF FATHER (city or town):
(State or country): Sweden
12 MAIDEN NAME OF MOTHER: Nelson
13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Germany

14 Informant (Address): Wm T Johnson 703 S Rotmar

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
(a) Pneumonia 3rd Degree
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
Signed Oct 19 G C Glades M. D.
(Coroner)
(Address) 143 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem Oct 21 1927
Date of Burial

20 UNDERTAKER: William Eck ADDRESS 516 North Ave

1527 C. HAMPSON JONES, M. D.

Spec.–7-17-26–A Co.–200 Blks.

E 26595

(Barrett)

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 26595

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. Balto City Hospitals No. 32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin O Barrett

(a) RESIDENCE NO. Balto City Hospitals St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) — — 1847

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	80 -	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Unknown

14 Informant _____
(Address) Unknown Friends

15 Filed _____, 19 _____ Registrar

C. H. THOMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14, 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1927 to Oct 14, 1927

that I last saw him alive on Oct 14, 1927

and that death occurred, on the date stated above, at 8 00 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis, Cholelithiasis, Chronic Myocarditis

_____ (duration) Unknown

CONTRIBUTORY (Secondary) Myocardial Insufficiency

_____ (duration) — yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct. 12, 27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) _____ M. D.

, 19 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park	10/17 1927
20 UNDERTAKER	ADDRESS
J. F. Shaughnessy	1318 Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 26596

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26596

CERTIFICATE OF DEATH.

160

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 244 S. Durham St. (Ward) 17-4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Stachowicz

(a) RESIDENCE. No. 244 S. Durham St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	W h.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Stachowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Carolina Brzezkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs William Stachowicz
(Address) 244 S Durham St

15 Filed .. 19 .. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18th 1927, to Oct 18th 1927, that I last saw h[im] alive on . 1927, and that death occurred, on the date stated above, at 10.05 A m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl L Ulrain, M. D.

Oct 18, 1927 (Address) 30 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary cem	Oct 20 19 27
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26597

CERTIFICATE OF DEATH

X74 001

E 26597

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 21-36 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Scalcat

(a) RESIDENCE NO. Maple avenue, St. Helena

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER ? Unknown

11 BIRTHPLACE OF FATHER (City or town) ? Unknown

(State or country)

12 MAIDEN NAME OF MOTHER ? Unknown

13 BIRTHPLACE OF MOTHER (city or town) ? Unknown

(State or country)

14 Informant

(Address) Records

15 Filed ..... 19 .....

AKA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1927, to Oct. 18, 1927, that I last saw her alive on Oct. 18, 1927, and that death occurred, on the date stated above, at 3:25 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage - thrombosis undetermined

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gen. & Sub.

(Signed) C. Hudson Bond, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Sacred Heart cem Oct 20 1927

20 UNDERTAKER — ADDRESS

John C. Miller 2435 Eutaw

40

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26598

CERTIFICATE OF DEATH.

E 26598

REGISTERED NO. 13

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 Warner ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis X. Mitchell

(a) RESIDENCE NO. 1206 Warner ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 12 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Dennis J. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Alice Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Dennis J. Mitchell (Address) 1206 Warner St

15 Filed Oct 20 1927 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1927, to Oct 18, 1927

that I last saw him alive on Oct 18, 1927

and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical symptoms

(Signed) Edward Horn, M. D.

Oct 19, 1927 (Address) 107 East Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Oct 20 1927

20 UNDERTAKER F. X. Mauser & Son — ADDRESS 703 Harford Av

Spec.—7-17-26—A Co.—200 Bks.

E 26599

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 26599

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1919 E. Fairmount Ave. St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Fischer

(a) RESIDENCE NO. 1919 E. Fairmount Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip J. Fischer

6 DATE OF BIRTH (month, day, and year) Feb. 24 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	60	7	22 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. MD.

PARENTS

10 NAME OF FATHER Henry Arnold

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER --------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Philip J. Fischer

(Address) 1919 E. Fairmount Ave.

15 Filed ..... 19 .....

Registrar

OCT 20 1927 HAMSON

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 17th. 1927

17 I HEREBY CERTIFY, That I attended deceased from [redacted] Dec 29 19 26, to Oct 17 19 27,

that I last saw her alive on Oct 15 19 27,

and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma with Metastasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of Jan 20/27

Was there an autopsy? no

What test confirmed diagnosis? Microscopic & operation

(Signed) J. H. Carter, M. D.

10-19-27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gordon PR — Date of Burial 10/20/27

20 UNDERTAKER Philips Henrig — ADDRESS 2016 Orleans St.

Spec.—1-12-23—M&T—500 Bks.

E 26600

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26600

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 Brookfield ave ST., 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Hettleman

(a) RESIDENCE No. 2012 Brookfield ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Hettleman

6 DATE OF BIRTH (month, day, and year) Aug 15-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	47	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rag Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Hettleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Kahlen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19/27

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1927, to Oct. 19, 1927, that I last saw him alive on Oct. 19, 19 27, and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lung with metastasis to stomach

(duration) yrs. 8 mos 1 ds.

CONTRIBUTORY (Secondary) Exhaustion - Gradual starvation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Frank R. Smith, M. D.

X. 20, 1927 (Address) 922 E. Centre

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Mt Lebanon Rosedale	10/20/27
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

FILED 1927 HAMSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 26601

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26601

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2214 Whittier ave ST., WARD) 13-59

REGISTERED No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Simon Brenner

(a) RESIDENCE No. 2214 Whittier ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Brenner

6 DATE OF BIRTH (month, day, and year): Unk.

7 AGE: Years 64 | Months — | Days — | If LESS than 1 day, ... hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Jack Brenner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Ida Brenner

(Address) 2214 Whittier ave

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/18 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 19 27, to Oct 18, 19 27, that I last saw him alive on Oct 18, 19 27, and that death occurred, on the date stated above, at 5.45 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Isidore S. Levy, M. D.

Oct 19 27 (Address) 2325 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 10/20 19 27

20 UNDERTAKER: Jack Levin

ADDRESS: 1139 Edmondson Ave

Spec.—12-9-25—A Co.—200 Bks.

E 26602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 E 26602

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-60 Ward)

2-FULL NAME Mrs. Mary Levin

(a) RESIDENCE NO. 1632 Ruxton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Levin

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Louis Goldberg

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rubanow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Louis Levin

(Address) 1632 Ruxton Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct 18/27

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927, to Oct 18, 1927, that I last saw h[illegible] alive on Oct 18, 1927 and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Failure

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Carbuncle

(duration) ..... yrs. ..... mos. 1/2 ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) C. Hyman, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Date of Burial 10/20 19

20 UNDERTAKER Jacob Levin & Sons ADDRESS 1632 Ruxton Ave

Spec.—12-9-25—A Co.—200 Bks.

E 26603

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26603

CERTIFICATE OF DEATH.

52

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., 610 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Fox.

(a) RESIDENCE NO. 407 N Collington St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec 27 1907

7 AGE: Years 19 Months 9 Days 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Abe Fox

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Merenbloom

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Russia

14 Informant Abe Fox

(Address) 407 N Collington Ave

15 Filed_____, 19____ _____ Registrar

By _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17

I HEREBY CERTIFY, That I attended deceased from 9-22, 1927, to 10-18, 1927, that I last saw h[illegible] alive on 10-18-27, 1927, and that death occurred, on the date stated above, at 4 [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) ____ yrs. ____ mos. 5 ds.

CONTRIBUTORY (Secondary) Subacute Bact endocarditis Rheumatic Fever - Hyper. Heart

(duration) 11 yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of_____

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Milton Sweet, M. D.

10/18, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hebron Rosedale Date of Burial 10/20 1927

20 UNDERTAKER Jack Lurz ADDRESS 1439 E Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26604

90 E 26604

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 100 N. Front St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Heck

(a) RESIDENCE NO. 100 N. Front St. adm 13-136 St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Heck

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE: Years 63 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer): also Jeweler

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Geo Heck

11 BIRTHPLACE OF FATHER (city or town): Balto.

(State or country)

12 MAIDEN NAME OF MOTHER: Julia Wallgren

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Mrs. Julia Heck

(Address): 13-13 Fountain St. a.

15 Filed....., 19..... OCT 20 1926 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18. 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Val. dis. Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Edw. J. Daley, M. D.

Oct. 18. 27 (Coroner)

, 1927 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem Date of Burial: Oct 21 1927

20 UNDERTAKER: Robert Brooks & Son ADDRESS: Calhoun & Hollins sts

Spec.—1-12-23—M&T—500 Blks.

E 26605 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26605

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Baltimore City Hospitals ST. 234 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cristo Styliati

(a) RESIDENCE NO. 1711 Aliceanna st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE: Years 46 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

10 NAME OF FATHER George Styliati

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant (Address) Hospital Records

Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1927, to Oct. 16, 1927,

that I last saw h[illegible] alive on Oct. 16, 1927

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculosis

From Lydia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path & Clinical

(Signed) [illegible], M. D.

10-, 1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 10/20 1927

20 UNDERTAKER: George & Ruth — ADDRESS: 1730 Harford Ave

OCT 20 1927 HAMPSON JONES, M.

Spec.—1-10-21—M&T—1500 Bks.

E 26606 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Bloomberry ST. 24-34 WARD)

REGISTERED NO. 74081

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick D. Mc Mahon

(a) RESIDENCE No. 114 Bloomberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 10-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 18

(b) General nature of industry, business, or establishment in which employed (or employer) Repairing Shell boiler

(c) Name of employer United R.R. Co.

9 BIRTHPLACE (city or town) Ire.
(State or country)

PARENTS

10 NAME OF FATHER Patrick Mc Mahon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Lord

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs Margaret Snyder
(Address) 1020 Jackson St

15 Filed , 19 H. A. [illegible], Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1927, to Oct 17, 1927

that I last saw h~~e~~alive on Oct 17, 1927

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

19 . 1927 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Oct 21, 1927
20 UNDERTAKER	ADDRESS
John J Lowe & Son.	901 Fulton Ave

Spec.—1-10-21—M&T—1500 Bks.

E 26607 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26607

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 W. Hayward Ave. WARD) 27-55

REGISTERED NO. 75002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella K. Bruggy.

(a) RESIDENCE No. 705 W. Hayward Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 16-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63.	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Morton Bruggy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Ann Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Rose Campodonico (Address): 705 W. Hayward Ave

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19th 1927.

17

I HEREBY CERTIFY, That I attended deceased (from Oct 10 . 1927 . to Oct 18 . 1927 .

that I last saw h[illegible] alive on Oct 17 . 1927 .

and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxalgia Paralysis & Embolism (duration) 1 yrs. 2 mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & clinical examination

(Signed) [illegible] M. D.

Oct 19 1927 (Address) 706 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 21st 1927
20 UNDERTAKER	**ADDRESS**
John J Cowan & Son.	901 Holliday St

Spec.—1-10-21—M&T—1500 Bks.

E 26608 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26608

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1178 S. Calhoun ST. 19-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ida E. Pickett

(a) RESIDENCE NO. 111 So Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Lewis W. Pickett

6 DATE OF BIRTH (month, day, and year) 8/28/1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. (State or country) Md

PARENTS

10 NAME OF FATHER Wesley Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane C. Wall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Lillie J. Carr (Address) 117 S. Calhoun St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1926, to Oct 19, 1927, that I last saw her alive on Oct 19, 1927, and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Clinical

(Signed) Estelle Hennessy, M. D.

Oct. 19 27 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL Oct. 21 1927

20 UNDERTAKER George L. Schwab ADDRESS 2101 Eutaw St.

Spec. 7-17-26—A Co. 100 Bks.

E 26609

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26609

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hosp. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Petzold

(a) RESIDENCE NO. Brannon Ave-Edgemere: Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2 1927

7 AGE — Years — Months 4 Days ~~Four~~ 16

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brannon ave-Edgemere Md (State or country) Md.

PARENTS

10 NAME OF FATHER Clifton Petzold

11 BIRTHPLACE OF FATHER (City or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Thumma

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)

14 Informant Mother (Address) Brannon ave-Edgemere Md.

15 Filed OCT 20 1927, 19 ..... Registrar

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1927, to Oct 18, 1927, that I last saw him alive on Oct 18, 1927, and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Cholera Infantum & Marasmus

(duration) yrs. 2 mos. da.

18 Where was disease contracted

If not at place of death? at Edgmere Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Geraghty M. D.

. 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — Date of Burial: Oct 20 1927

20 UNDERTAKER: John F Deery — ADDRESS: 75 Light

Spec.—1-12-23—M&T—500 Bks.

E 26610

Dr Kolb 1203 Light Lo

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26610

CERTIFICATE OF DEATH.

5-001

23-32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1731 Olive ST., (WARD)

2-FULL NAME Mary E Kirby

(a) RESIDENCE NO. 1731 Olive ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George B Kirby

6 DATE OF BIRTH (month, day, and year) March 7, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Alexander Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eleanor Broze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cuba

14 Informant Geo. B. Kirby

(Address) 1731 Olive St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 24/27, 19 ..., to Oct 15/27, 19 ..., that I last saw her alive on Oct 15/27, 19 ..., and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Cerebral)

(duration) yrs. 1 1/2 mos ds.

CONTRIBUTORY (Secondary) Hyp Hem Rem Arter Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Amy B Kolb, M. D.

Oct 17/27 (Address) 1203 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Oct 22 1927
20 UNDERTAKER	ADDRESS
W. M. Cook	522 Hartford Ave

OCT 20 1927 HARRY W. JONES, REGISTRAR

Cor.—12-9-25—A Co.—200 Bks.

E 26611

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26611

CERTIFICATE OF DEATH.

188-003

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Enroute to St. Joseph Gospital, St.) (6-4-1 Ward)

2-FULL NAME August H. Holthaus

(a) RESIDENCE NO. 1410 Darley Ave St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria Holthaus

6 DATE OF BIRTH (month, day, and year): Sep-19-1851

7 AGE — Years: 75 — Months: 0 — Days: 28 — If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: William Holthaus

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: John A. Holthaus

(Address) 1113 N. Washington St.

15 Filed....., 19.....

C. HARRY JONES, Registrar

Per_____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Frac. Skull-Legs- thigh & intraabdominal injuries.

Run over by autotruck at Harford & 25th St. (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) J. E. Gallen (Coroner) M. D.

10-19-27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs.. ....mos.. ....ds. In the State ....yrs.. ....mos.. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Oct 20 1927

20 UNDERTAKER: Harry D. Witzke — ADDRESS: 1531 W. Lombard

Spec.—7-17-26—A Co.—200 Blks.

E 26612

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26612

CERTIFICATE OF DEATH

REGISTERED NO. _____

1-PLACE OF DEATH Univ Hospital

City of BALTIMORE: (No. 9-44 St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Ziegler

(a) RESIDENCE NO. 2447 Robb St St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ida L Ziegler

6 DATE OF BIRTH (month, day, and year) Feb 4 1897.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iceman

(b) General nature of industry, business, or establisbment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Brila, Md.

(State or country)

PARENTS

10 NAME OF FATHER Frederick Ziegler

11 BIRTHPLACE OF FATHER (City or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country)

14 Informant Ida L Ziegler

(Address) 2447 Robb St.

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1927, to Oct 18, 1927, that I last saw h[illegible] alive on Oct 18, 1927, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. Junction

_____ (duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (Secondary) Appendectomy

_____ (duration) _____ yrs. _____ mos. 10 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? Yes Date of Oct 8, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. S. Anderson, M. D.

, 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — Date of Burial Oct 22 27

20 UNDERTAKER Harry H. Weitzke — ADDRESS 1531 W. Lombard St.

Spec.—7-17-26—A Co.—200 Bks.

E 26613

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26613

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No.) St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta O Stenhouse

(a) RESIDENCE NO. 2004 Bandon Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Sam. Bruchler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elener ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) Same

15 Filed ....., 19 .....

Registrar

74. Am.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10/1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1927, to Oct. 10, 1927, that I last saw h[illegible] alive on Oct. 10, 1927, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic - acute

Cerebral Sclerosis

Hypertension

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms.

(Signed) C. Holmes Boyd M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
London Park Cemetery	Oct 11 19

20 UNDERTAKER Harry N. Weitzel ADDRESS 1537 W. Lombard St

Cor.—12-9-25—A Co.—200 Bks.

E 26614 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26614

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 737 W Lesginton St. 54 Ward)

2-FULL NAME Martin Zilinskas

(a) RESIDENCE NO. 737 W Lesginton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. — mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1874

7 AGE 53 Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Liethvanina

PARENTS

10 NAME OF FATHER Peter Zilinskas

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Liethvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Liethvania

14 Informant C. Skinkis

(Address) 2609 W Fermont Ave.

15 Filed 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Oct 19/27 (Signed) G E Slades M. D.

(Coroner)

19 (Address) 1743 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. Date of Burial Oct. 20. 1927

20 UNDERTAKER C. B. Kuchauskas ADDRESS 637 S Paca St

OCT 20 1927 HAMPSON JONES M.

Spec.—1-12-23—M&T—500 Bks.

E 26615 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 E 26615

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Kernan Hotel ST. (or WARD)

2-FULL NAME Kate Haig

(a) RESIDENCE NO. Kernan Hotel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6 DATE OF BIRTH (month, day, and year) July 4, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George Haig

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Kate Proudfoot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S. A.

14 Informant (Address) Mrs. Lizzie M. Miller Kernan Hotel

15 Filed ---, 19 --- Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 8th, 1927, to Oct. 19, 1927, that I last saw her alive on Oct 19, 1927, and that death occurred, on the date stated above, at about 3 P m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia Jaundice Myocarditis

(duration) --- yrs. --- mos --- ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) --- yrs. --- mos. --- ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

10-26, 1927 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 10/19 19 27

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert St

Oct 26 1927 HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 26616 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26616

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 12 WARD)

2-FULL NAME Estella - Gray

(a) RESIDENCE NO. 1630 E Monument ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of or (b) WIFE of William Gray

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE: Years 41 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaker 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Randolph

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Ella —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 20 1927, 19 HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1927, to Oct 15, 1927, that I last saw her alive on Oct 15, 1927, and that death occurred, on the date stated above, at 12-[illegible] p m.

The CAUSE OF DEATH* was as follows:

Chronic rheumatic heart disease

Acute myocardial insufficiency

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Allan Blossom, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Oct 21 1927

20 UNDERTAKER Wm. H. G. Elliott ADDRESS 1720 Washington

Spec.—I-12-23—M&T—500 Blks.

E 26617

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26617

CERTIFICATE OF DEATH.

175

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 650 Pitcher ST. 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses J. Dorsey

(a) RESIDENCE NO. 650 Pitcher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ida Dorsey

6 DATE OF BIRTH (month, day, and year) Aug. 31, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hatfield Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mary Randall Ferguson (Address) 650 Pitcher St

15 Filed ..., 19 ... Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4th, 1927, to Oct 18, 1927, that I last saw him alive on Oct. 17th, 1927, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows: Stomach Cancer

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Aortic Disease

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

10/18, 1927 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn by	Oct 19 1927
20 UNDERTAKER	ADDRESS
Theodore L. White	1315 Madison Ave

Cor.—12-9-25—A Co.—200 Bks.

E 26618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7400 E 26618

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 353 Canal alley St. 11-24 Ward)

2-FULL NAME Thos. H. Henderson

(a) RESIDENCE NO. 353 E. Canal alley Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza Henderson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years about 62 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Minister

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Thomas Henderson

(Address) 353 Canal St.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 17, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or neither) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): no other history

(duration) yrs. mos. ds.

(Signed) J. T. Hemeday (Coroner) M. D.

Oct. 18 1927 (Address) 352 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial Oct. 20 1927 19

20 UNDERTAKER: Mrs. R. A. Ellicott ADDRESS 1223 Eastern ave

OCT 20 1927 C. HAMPSON JONES

Spec.—1-12-23—M&T—500 Blks.

E 26619 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 W 37th ST. 13-52 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Embly

(a) RESIDENCE NO. 701 W 37th ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: George F. Embly

6 DATE OF BIRTH (month, day, and year): Apl 4 - 1859

7 AGE: Years 68 | Months 6 | Days 16 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penn

PARENTS

10 NAME OF FATHER: Adam Hondle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Michel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Ethel Spinker 701 W 37th St

15 Filed ....., 19 Per ..... Recorder

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1926, to Oct 19, 1927, that I last saw her alive on Oct 18 1927 and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3421 Hudson Ave

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Isaac Druker, M. D.

(Address) 846 W 36th St. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Mary's Cemetery Hampden	Oct 22 1927
20 UNDERTAKER: Holt J Turner & Co	ADDRESS: 1105 Broadway

OCT 20 1927 C. HAMPSON JONES, M.D.

Spec.—1-10-21—M&T—1500 Bks.

E 26620 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26620

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospl. ST., 14-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna May Lee.

(a) RESIDENCE NO. 335 N. Caehon Sr. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	Black	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hours or min.
	3			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Wm Witt Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Lena Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital Records.

15 Filed ..... 19 ..... Registrar

OCT 20 1927 T. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-19-27 19

17 I HEREBY CERTIFY, That I attended deceased from 10-17-27, 19 , to 10/19/27, 19 ,

that I last saw her alive on 10/19/27, 19 ,

and that death occurred, on the date stated above, at 6.15 a m.

The CAUSE OF DEATH* was as follows:

First and Second degree burns of almost entire body surface.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchiopneumonia

(duration) yrs. mos. 1 ds.

Was disease contracted if not at place of death? Home.

Did operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Cecil R. Hall, M. D.

19 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 10/20 19 27

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St

Spec. 7-1-26 A Co. 200 Bks.

E 26621

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26621

CERTIFICATE OF DEATH

24-001

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2860 Kentucky Ave St. 9-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine R P. Wissel

(a) RESIDENCE NO. 2860 Kentucky Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William F Wissel

6 DATE OF BIRTH (month, day, and year): Oct 7 - 1854

7 AGE — Years: 73 — Months: — — Days: 17 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Baltimore

PARENTS

10 NAME OF FATHER: Geo Abelander

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Weis

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs Pauline Koerber

(Address) 2860 Kentucky Ave

15 Filed ..... 19 .....

Registrar

OCT 20 1927 C. HAMPSON JONES, M. D. CITY REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct 19 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1927, to Oct 19, 1927, that I last saw her alive on Oct 19, 1927, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. J. Neef, M. D.

19 , 19 (Address) 405 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cem — Date of Burial: Oct 21 1927

20 UNDERTAKER: John Merrick — ADDRESS: 2008 Orleans

Cor.—12-3-25—A Co.—200 Bks.

E 26622 HEALTH DEPARTMENT—CITY OF BALTIMORE 167-001 E 26622

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 546 Parkman.

City of BALTIMORE: (No. 546 Parkman St. 15-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Poulsen

(a) RESIDENCE NO. 1905 Clifton Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie E. Poulsen

6 DATE OF BIRTH (month, day, and year): November 25, 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	11 10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Poulsen

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Mason

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Maryland

14 Informant: Mrs. Fannie E. Poulsen

(Address) 1905 Clifton Ave.

15 Filed ..... 19 ..... Registrar

O 1927 C. HAMPSON JONES

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Gas (Poisoning) Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

(Coroner)

10/19, 1927 (Address) 3692 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn Cemetery	Oct. 22 19 27

20 UNDERTAKER E. Leroy Stiffler ADDRESS 1258 E. North ave.

Spec.—1-12-23—M&T—500 Blks.

E 26623

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 Inverness Ave ST. Morrell Park 21 WARD) REGISTERED NO. 25-72

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin J. Heinrich

(a) RESIDENCE No. 1300 Inverness Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: — — —

6 DATE OF BIRTH (month, day, and year): 10 Oct. 1881

7 AGE: Years 46 Months 10 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Knabe

9 BIRTHPLACE (city or town) (State or country): Hungary

10 NAME OF FATHER: John Heinrich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungary

12 MAIDEN NAME OF MOTHER: Anna Henning

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary

14 Informant: Balaus M Wagner

(Address) 1300 Inverness Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927, to Oct 18, 1927, that I last saw h alive on Oct 18, 1927, and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Crushing of leg,

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Crushing of leg (crushing)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Dill M. D.

10/19/1927 (Address) 1504 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Oct 21 1927

20 UNDERTAKER: Mrs Mrs Jos S Finch

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26624

CERTIFICATE OF DEATH.

E 26624

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 69 Ward)

2-FULL NAME Jno Jordan

(a) RESIDENCE NO. 1931 Cerman St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Man

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie Jordan

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Biscuit Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 13

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Jno Jordan

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Sumpter

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Maggie Jordan

(Address) 1931 Cerman

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory Jordan (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

Oct 18 (Signed) C J Pelzy (Coroner) M. D.

, 1927 (Address) 1629 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State Halfway yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial Oct 21 1927

20 UNDERTAKER: Henry Lutz ADDRESS 1203 Broadway

OCT 1927 C. HAMPSON JONES, M. D.

Spec.—7-17-26—A Co.—200 Bks.

E 26625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 26625

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. St. Joseph Hospital 9-17 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Zeller

(a) RESIDENCE NO. St. Joseph Hospital St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): Not known ?

7 AGE — Years: about 65 — Months — Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Md

PARENTS

10 NAME OF FATHER: Anthony Zeller.

11 BIRTHPLACE OF FATHER (City or town)
(State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant: Records of St. Joseph's Hospital
(Address) Caroline & Aisquith Sts

15 Filed ..... 19 .....
Per ..... Registrar

C. HAMPSON JONES, M. D.
1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 19, 1927 — 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Oct 19, 1927, that I last saw h[im] alive on Oct 19, 1927, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no. Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

Oct. 20, 1927 (Signed) H Laurence Fahrney, M. D.

(Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Oct 21 1927

20 UNDERTAKER: Henry Hoech Son — ADDRESS: 1301 E Eager St

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26626

CERTIFICATE OF DEATH.

64 E 26626

1-PLACE OF DEATH

City of BALTIMORE: (No. Pronounced dead at the South Baltimore General Hospital ward) 24-33

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Rich.(C)

(a) RESIDENCE NO. Do not know. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	Colored	Do not know.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35	---------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed_____, 19_____ Registrar

1815

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

10/20 1927 (Address) 2017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs..... mos.,..... ds. In the State.....yrs..... mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26627

CERTIFICATE OF DEATH.

90

E 26627

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 118 W. Hill St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Jones. (C)

(a) RESIDENCE NO. 118 W. Hill St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	70	---		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Police Report. S. D.

(Address)

15 Filed_____ 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) Albert Reinhardt M. D.
(Coroner)

10/20 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND
1927 C. HAMPSON JONES, M. D.
Commissioner of Health.
FROM THE MORGUE.

Spec.—1-12-23—M&T—500 Bks.

26628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 E 26628

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 1352 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Hansler

(a) RESIDENCE NO. 3438 Roland ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

7 DATE OF BIRTH (month, day, and year): 1879

8 AGE — Years: 48 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: John Hansler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Hospital Records

(Address)

15 Filed 10-16-1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 15, 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1925, to Oct. 15, 1927,

that I last saw him alive on Oct. 15, 1927

and that death occurred, on the date stated above, at 10.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Laboratory

(Signed) L. E. Madden, M. D.

10-16, 1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26629

E 26629

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4403 Garrison Blvd WARD 27-56

2-FULL NAME Gertrude Krause

(a) RESIDENCE NO. 4403 Garrison Blvd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles E Krause

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co Md.

PARENTS

10 NAME OF FATHER Romaine Hale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co Md

12 MAIDEN NAME OF MOTHER Conaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jenkins

14 Informant Charles E Krause

(Address) 4403 Garrison Ave

15 Filed ... 19 ... Registrar

C. HAMPSON JONES, M. D.

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 14 1927 to Oct 14 1927.

that I last saw her alive on Oct 14 1927

and that death occurred, on the date stated above, at 10-4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos 15 ds.

CONTRIBUTORY (Secondary) Secondary Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) C. Gilly M. D.

Oct 19 1927 (Address) 3W Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER W. E. Gilly W E Eutaw

Spec.—1-12-23—M&T—500 Bks.

E 26630

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26630

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General ST. Hospital WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Wachter

(a) RESIDENCE No. 1057 Hanford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Wachter

6 DATE OF BIRTH (month, day, and year): Jan 1 - 1881

7 AGE: Years 46; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Wachter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungary

12 MAIDEN NAME OF MOTHER: Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Same

14 Informant: Mary Wachter

(Address): 1057 Hanford Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 19 27, to Oct 19, 19 27, that I last saw him alive on Oct 19, 19 27, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis (Fibrinous)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Louis F. Lang, M. D.

10/19, 1927 (Address) W. Baltimore & Pine.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: Oct 22 1927

20 UNDERTAKER: Frank Cook - son

ADDRESS: 1906 Holland Ave

10-927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 26631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26631

REGISTERED NO. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Haraee Snowden

(a) RESIDENCE NO. 1328 Argyle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John H. Snowden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Catonsville Md.

12 MAIDEN NAME OF MOTHER Nancy Milbourne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Catonsville Md

14 Informant (Address) Nancy Snowden 1328 Argyle ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927, to Oct 20, 1927, that I last saw him alive on Oct 20, 1927 and that death occurred, on the date stated above, at 8 45 a m

The CAUSE OF DEATH* was as follows:

Purulent Conjunctivitis

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical

(Signed) Myron G. Tull, M. D.

10/29/27 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem

DATE OF BURIAL 10/31 1927

20 UNDERTAKER Daniel Eaton

ADDRESS 1/0 Penna Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26632 | CERTIFICATE OF DEATH. | E 26632

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 103 N. Carey St. 18-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Storey

(a) RESIDENCE No. 103 N. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie J. Story

7 DATE OF BIRTH (month, day, and year): April 9th 1869

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Edgewater Iron

9 BIRTHPLACE (city or town) (State or country): Pittsburg Pa.

10 NAME OF FATHER: Peter Story

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary M. E. Runke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Mrs. L. Story Pittsburg Pa.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1927 to Oct. 18, 1927, that I last saw him alive on Oct. 18, 1927, and that death occurred, on the date stated above, at 11. P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

Complication Disease (duration)* 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Positive

(Signed) Dr Guttermaid, M. D.

10-18-1927 (Address) 708 Union St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pittsburg Pa. DATE OF BURIAL: Oct 20th 1927

20 UNDERTAKER: F. B. Hufnagel ADDRESS: 1501 Madison Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26633 E 26633

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH —

City of BALTIMORE: (No. City Jail 10-15 Ward)

2-FULL NAME Andrew G. Gill.

(a) RESIDENCE NO. Toronto Canada St. _____ Ward _____

(Usual place of abode) 1049 Bloor at (If not resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Toronto

(State or country) Canada

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Central Dist. Police

(Address) Request

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned

Duel Known (duration) ..... yrs. ..... mos. 0 ds.

CONTRIBUTORY (Secondary) .....

Duel Known (duration) ..... yrs. ..... mos. ..... ds.

Oct 20 (Signed) H. T. Riley M. D.

(Coroner)

, 1927 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IF LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lindsay Ontario Date of Burial 10-20 1927

20 UNDERTAKER Casady. ADDRESS Bernard C Harkins 100 S Howard St

Spec.–7-17-26—A Co.—200 Bks.

E 26634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 26634

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph's Hospital St. Ward) 27-W

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Bergmeister

(a) RESIDENCE NO. 4511 Reitzel Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Bergmeister

6 DATE OF BIRTH (month, day, and year): Feb 13 1873

7 AGE — Years: 54 Months: 8 Days: 6 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Adolph Bergmeister

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Schaffenby

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Margaret Bergmeister

(Address) 4511 Reitzell Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct. 14 - 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to 10/19, 1927,

that I last saw h[illegible] alive on 10/19, 1927,

and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Lung Abscess

Carcinoma Liver

(duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) Brain Abscess Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Path

(Signed) H Lawrence Fabian, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Parkwood Cemetery	Oct 22 1927
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2173 E. Pr

26 1927 C. HAMPSON [illegible] M D

Per

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26635

CERTIFICATE OF DEATH

12 E 26635

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 804 Ridgely St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvatore Gaglione

(a) RESIDENCE NO. 804 Ridgely St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Vinza Gaglione

6 DATE OF BIRTH (month, day, and year): Sept 22 1864

7 AGE 57 Years 6 Months 26 Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fruit Store

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Ignathus Gaglione

11 BIRTHPLACE OF FATHER (City or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Mrs Vinza Gaglione

(Address): 804 Ridgely St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1927, to Oct. 18, 1927, that I last saw him alive on Oct. 17, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Myocardial + Cardiac Dilatation

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Thos C Blake M. D.

, 19 (Address) 1014 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial: Oct 21 1927

20 UNDERTAKER: Jos Jacobs & Son ADDRESS: 2178 E. Pra

OCT 1927 C. HAMILTON DAVIS

ARH

Spec.—1-12-23—M&T—500 Pks.

E 26636

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26636

179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3037 Huntingdon Ave ST.) (WARD) 51

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noah Edward Reese

(a) RESIDENCE No. 3037 Huntingdon Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Magdalena Reese

6 DATE OF BIRTH (month, day, and year) Feb 10, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cranberry Carroll Co Maryland

PARENTS

10 NAME OF FATHER John Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Suzanne Kittinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) E. V. Reese 3350 Chestnut Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 5 . 1927 . to Oct 19 . 1927 .

that I last saw h/m alive on Oct 19 1927

and that death occurred, on the date stated above, at 5.58 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis; Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. M. Wilson, M.D.

. 19 (Address) 873 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wesley Chapel Cemetery	Oct 22, 1927

20 UNDERTAKER Edmondson

ADDRESS 3350 Chestnut Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26637

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26637

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 127 Cread Ave S. W. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Evelyn Beatrice Webb

(a) Residence No. 127 O'Read Ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-If married, widowed, or divorced, HUSBAND of (or) WIFE of Alvin A. Webb

6-DATE OF BIRTH (month, day and year) 1-24-07.

7-AGE. 20 yrs. 8 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. A W. 031

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Charleston W Va

PARENTS.

10-NAME OF FATHER, John Pellam

11-BIRTHPLACE OF FATHER (city or town) (State or Country). W Va

12-MAIDEN NAME OF MOTHER, Grace Coleman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). W Va

14- (Informant) Alvin A. Webb

(Address) 127 Cread Ave

15-

Filed ..... 192..... Registrar.

AFH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-18-27

17- I HEREBY CERTIFY, That I attended deceased from 10-8 19 27 to 10/18 19 27

that I last saw h[illegible] alive on 10/18 19 27

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows: Pneumonia, Degenerative

Pulmonary Edema

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) David Gilbert M. D.

10/19 19 27 (Address) N Or Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Marys Ham[illegible]

DATE OF BURIAL. Oct 21 19 27

20-UNDERTAKER. Edmondson & Son

ADDRESS 3617 Chestnut Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26638

CERTIFICATE OF DEATH.

147 E 26638

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Caplan

(a) RESIDENCE NO. 16 S Patterson Park Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Caplan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER Robert Cooper

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Cooper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Robert Caplan

(Address) 16 S Patterson Park Ave

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 18 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 9, 1927, to Oct 18, 1927, that I last saw her alive on Oct 18, 1927, and that death occurred, on the date stated above, at 5.40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism 15 min

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Infarct of Lung

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm Schuman, M. D.

Oct 18, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Date of Burial Oct 21, 1927

20 UNDERTAKER Sol Levinson & Bro ADDRESS 1127 E Baltimore St

OCT 20 1927

C. HAMPSON JONES, M. D.

Registrar

Spec.—1-12-23—M&T—500 Blks.

E 26639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 26639

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 S. Kenwood Ave. ST. 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter . Wietrzykowski

(a) RESIDENCE NO. 913 S. Kenwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 7 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	-	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Vincent . Wietrzykowski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Lucia . Pawlowicz

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14

Informant Mr. Vincent Wietrzykowski
(Address) 913 S. Kenwood Ave.

15

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 17 1927, to Oct 20 1927.

that I last saw him alive on Oct 20 1927.

and that death occurred, on the date stated above, at 340 P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Reynolds, M. D.

(Address) 1210 Dolphin Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Oct 21 1927
20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26640

E 26640

CERTIFICATE OF DEATH.

REGISTERED NO. 1279

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 Goodwood Rd ST. 27th WARD)

2-FULL NAME George Henry Pohl

(a) RESIDENCE NO. 204 Goodwood Rd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie B. Tasche Pohl

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) coffee + tea

(c) Name of employer Kronberger

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Adam Pohl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Daughter - Elsie Hales

(Address) 204 Goodwood Rd.

15 Filed . . , 19 . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1927 to Oct. 19, 1927.

that I last saw him alive on Oct. 18, 1927

and that death occurred, on the date stated above, at 8 15 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & hypertension

Chr. Myocarditis - chronic nephritis Hypertrophied Prostate (duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) myocardial insufficiency (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Evidence.

(Signed) Geo. B. Dyhert, M. D.

, 19 (Address) 2807 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 10/22 1927

20 UNDERTAKER E. V. Fanning & Son

ADDRESS 1385 Lafayette Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26641

E 26641

CERTIFICATE OF DEATH.

91-002

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hospital 22-31 St. _____ Ward)

2-FULL NAME Chas Stewart

(a) RESIDENCE NO. 110 Henrietta St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Stewart

6 DATE OF BIRTH (month, day, and year) March 15, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day..... hrs. or.....min.
	55	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER William Stewart

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Adline Hilton

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Sarah Stewart

(Address) 110 Henrietta St

15 Filed _____ 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cardiac Asthma 14 (duration) yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

Dr. F. C. Glade M. D.

(Signed) _____ (Coroner)

19 (Address) 1430 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial 10-21 19 27

20 UNDERTAKER Jos Brown & Son ADDRESS Baltimore

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26642

3 1 E 26642

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 719 Brannan Court. 42-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Johnson.(C)

(a) RESIDENCE NO. 719 Brannan Court. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	22	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Abel Johnson.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Eliza Reed.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Annie Parker.(C) aunt.

(Address) 921 Bevan St.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 18, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M Reinhardt M. D.
(Coroner)

10/20 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Birch Date of Burial 19

20 UNDERTAKER Wm. J. Brown & Son ADDRESS

Cor.—1-12-23—M&T—100 Bks.

E 26643 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mrs Hospital St. 14-20 WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Howard

(a) RESIDENCE NO. 180 & McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) 1872

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hostler
(b) General nature of industry, business, or establishment in which employed (or employer) 024
(c) Name of employer

BIRTHPLACE (city or town) md.
(State or country)

10 NAME OF FATHER John Howard

11 BIRTHPLACE OF FATHER (city or town) md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jane Woods

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

Informant Martha Howard
(Address) 604 S. Eutaw St.

Filed OCT 21 1927 192 C. HARRISON JONES, Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Exhaustion (duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

(Signed) C. G. Yates M. D.

10/21 192 (Address) 1218 Druid Hill Ave (Corner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL Oct 22 192 ?

20 UNDERTAKER Chas. H. Judson ADDRESS 416 N. Eutaw St.

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Bks.

E 26644 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26644

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2402 E. Hoffman ST., 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha M. Wolff

(a) RESIDENCE NO. 2402 E. Hoffmann ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry C. Wolff

6 DATE OF BIRTH (month, day, and year) October 5, 1881

7 AGE: Years 46 | Months 0 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John Bryson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Emma VonHelen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Henry C. Wolff

(Address) 2402 E. Hoffmann St.

15 Filed OCT 21 1927 C HAMPSON JONES, M.D. , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1927, to Oct 19, 1927

that I last saw h alive on Oct 18, 1927

and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. L. Haynes M. D.

(Address) 1710 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct. 22 1927

20 UNDERTAKER: Henry Auden & Sons Inc — ADDRESS: 1710 Fleet St.

Cor.—12-9-25—A Co.—200 Bks.

E 26645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26645

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 16-23 Ward)

2-FULL NAME LeRoy S Murdock

(a) RESIDENCE NO. 724 N. Stockton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 4 mos. 23 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27-1910

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	17	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) Penna RR
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Sam. Murdock

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Eliz Clunn

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Eliz Murdock
(Address) 724 Stockton

15 Filed....., 19.....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Pelvis (duration) yrs. mos. ds. Struck by P Ry auto

CONTRIBUTORY (Secondary) Shock (duration) yrs. mos. ds.

Oct 1 1927 (Signed) M. J. Riley (Coroner) M. D.
(Address) 16 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, Recent Residents.)
At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Oct 23 1927 Date of Burial

20 UNDERTAKER Sam. H Clare & Son ADDRESS

C. HAMPSON JONES, M.D.
OCT 26 1927

Spec.–7-17-26—A Co.—200 Bks.

E 26646

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26646 ✓

38

CERTIFICATE OF DEATH

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 412 Mott St 5-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Thompson

(a) RESIDENCE NO. 412 Mott St. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Wayland

6 DATE OF BIRTH (month, day, and year) Oct 8 1884

7 AGE: Years 43 Months 10 Days ..... IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Eden Morgan

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Baltimore Md

14 Informant Hattie Thompson

(Address) 412 Mott St

15 Filed ..... 19 .....

Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 19 27 to Oct 18 19 27

that I last saw h.. alive on Oct 18 19 27

and that death occurred, on the date stated above, at 12 20 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Carcinoma

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage

..... (duration) ..... yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Physical

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones M. D.

10-15-1927 (Address) 608 Fairmount Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. Date of Burial Oct 21 1927

20 UNDERTAKER Thos J. G. Locke ADDRESS 1302 Jeffer

OCT 21 1927

Spec.–7-17-26—A Co.—200 Bks.

E 26647

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26647

CERTIFICATE OF DEATH

X 16-002

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hosp St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Maynard

(a) RESIDENCE NO 1256 Baltimore Rd Sparrows Pt Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: N

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about July 1, 1927

7 AGE Years: Months: 3 Days: IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: N.D

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Sparrows pt. Md.

(State or country)

PARENTS

10 NAME OF FATHER Ernest Maynard

11 BIRTHPLACE OF FATHER (City or town) NC

(State or country) Ethel Williams

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) N.C.

(State or country)

14 Informant Mother: Mrs. Ernest Maynard

(Address) 1256 Baltimore Rd Sparrows Pt.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1927, to Oct 19, 1927,

that I last saw h.... alive on Oct 19, 1927,

and that death occurred, on the date stated above, at 12 10 P m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Impetigo Contagiosa Bacillary Dysentery

(duration) yrs. mos. 2 wks da.

18 Where was disease contracted

If not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. Douglas, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Henderson North Carolina Oct 21 1927 | Date of Burial

20 UNDERTAKER: George J Smith | ADDRESS: 1532 Hollins

Spec. 6-9-19 H. P. Co. 1000 Bks.

E 26648 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26648

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 S. Hilton St. 20-7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Lockwood Ironmonger.

(a) RESIDENCE No. 12 S. Hilton St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced (or) WIFE of Henry Wise Ironmonger

6 DATE OF BIRTH (month, day, and year) Mar. 15, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John T. Brashears.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Lockwood.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant (Address) Herbert Ironmonger. 12 S. Hilton St.

15 Filed . . . 19 . . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20, 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1927, to Oct. 20, 1927, that I last saw her alive on 1 A. M. Oct. 20, 1927 and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestines.

(duration) 1 (one) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Frank N. Ogden, M. D.

10 20 1927 (Address) 115 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 22 1927
20 UNDERTAKER Joseph B Cook	ADDRESS 1002 E Balto St

Spec.–7-17-26—A Co.—200 Bks.

E 26649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26649

REGISTERED NO. 38

1-PLACE OF DEATH

City of BALTIMORE: (No. 904 Rutland Ave St. 9-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Butts

(a) RESIDENCE NO. 904 Rutland Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1911

7 AGE — Years: 16 — Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brunswick Va.

PARENTS

10 NAME OF FATHER: Travers Butts

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Myrtle Lowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Myrtle Lowell Butts 904 Rutland Ave

15 Filed ..... 19 ..... Registrar

OCT 21 1927 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 18 19 27 to Oct 19 19 27

that I last saw h.. alive on Oct 19 19 27

and that death occurred, on the date stated above, at 9 55 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) [redacted]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [redacted] M. D.

Oct 19. 1927 (Address) 508 Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mecklenburg Co. Va — Date of Burial: 10-22 1927

20 UNDERTAKER: Jas. M. Skinner — ADDRESS: 1625 E. Broad St

Spec.–7-17-26—A Co.—200 Bks.

E 26650

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

E 26650

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 1637

City of BALTIMORE: (No. 806 S. Fourth St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bienlein

(a) RESIDENCE NO. 806 S. Fourth St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Bienlein

6 DATE OF BIRTH (month, day, and year) Feb. 7th 1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Elizabeth Bienlein Wife

(Address) 806 S. Fourth St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18, 1927

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred, on the date stated above, at 8 45 a. m.

The CAUSE OF DEATH* was as follows:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

..... 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — Date of Burial: Oct 22 1927

20 UNDERTAKER: Lilly & Zeller — ADDRESS: 4033 W. Fayette

Filed OCT 21 1927 C. HAMPSON JONES

Per .....

Spec.–7-17-26—A Co.—200 Bks.

E 26651

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26651

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. W 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Wallace

(a) RESIDENCE NO. Stemmers Run Balto Co Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Florence M.

6 DATE OF BIRTH (month, day, and year) Sept. 1862

7 AGE: 66 Years 5 Months 1 Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.

(State or country)

PARENTS

10 NAME OF FATHER Geo. Wallace

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Merle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Hospital Records

(Address) Balto City Hospital

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct. 19, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1927 to Oct. 19, 1927

that I last saw him alive on Oct 19, 1927

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Thrombosis of Brain Cord

Chronic Lumbar Osteitis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Senile Debility Primary

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) W. Engelke M. D.

10/19. 1927 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn Forest Rd	Oct. 21 1927
20 UNDERTAKER	**ADDRESS**
John J. Connelly	Essex

OCT 21 1927 C. HAMPSON Journal

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26652

CERTIFICATE OF DEATH.

129 E 26652

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1924 E 31st St. 2-4 Ward)

2-FULL NAME Helen Dorota

(a) RESIDENCE NO. 841 S. Bond St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced. ~~HUSBAND~~ of (or) WIFE of: Ludwig P. Dorota

6 DATE OF BIRTH (month, day, and year): 4/15/1868

7 AGE: Years 59 | Months 6 | Days 5 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town):

(State or country): Poland

PARENTS

10 NAME OF FATHER: Casper Janicki

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Marie Wasowska

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Poland

14 Informant: M. Dorota (Son)

(Address): 841 S. Bond

15 Filed_____, 19____

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/20 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/16, 1927, to 10/19, 1927, that I last saw h__ alive on 10/19, 1927, and that death occurred, on the date stated above, at 12:10 m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis.

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Cerebral hemorrhage & Paralysis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Thos D Ambidge, M. D.

10/20, 1927 (Address) 1623 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — Date of Burial: 10 24 1927

20 UNDERTAKER: W. J. Jackowski — ADDRESS: 1618 Eastern Ave

OCT 24 1927 HAMPSON JONES

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26653

CERTIFICATE OF DEATH.

E 26653

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 Mulliken ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Mae Hall

(a) RESIDENCE NO. 1720 Mulliken ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel O. Hall

6 DATE OF BIRTH (month, day, and year): Sept. 2. 1872

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	1	16	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country): Anne Arundel Co Md.

10 NAME OF FATHER: Washington Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel Co. Md.

12 MAIDEN NAME OF MOTHER: Ellen ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co. Md.

14 Informant: Victoria Mellusy (daughter)

(Address) 1720 Mulliken

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 18 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1927, to Oct. 18, 1927, that I last saw her alive on Oct. 18, 1927, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs mos 3 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Evd.

(Signed) W. L. Bluey, M. D.

, 19 (Address) 1570 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pasadena Md

DATE OF BURIAL: Oct 21 1927

20 UNDERTAKER: Robert E. Williams

ADDRESS: 515 McCulloh St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26654

E 26654

CERTIFICATE OF DEATH.

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Vincents Infant Asylum ST. WARD 63

2-FULL NAME Regina Burnham

(a) RESIDENCE NO. St Vincent's Infant Home ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 15 '27

7 AGE — Years: 4 Months: 4 Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child (60)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Laura Burnham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Mabel E Bacon

(Address) 100 E 20th St

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 20 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1927, to Oct 20 1927, that I last saw her alive on Oct 19, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 4 mos 4 ds.

CONTRIBUTORY (Secondary): Probably Grippe

(duration) yrs. 4 mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Those of Malnutrition

(Signed) Mabel E Bacon, M. D.

10/20 1927 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: 10/22 1927

20 UNDERTAKER: John T Lano — ADDRESS: 131 Light

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26655 HEALTH DEPARTMENT—CITY OF BALTIMORE 167-007 E 26655

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE (No. 232 Highland Ave St., 26-2 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reinold E Obermeyer

(a) Residence No. 232 Highland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct-20-27

7-AGE If LESS than 1 day,

yrs. mos. ds. 4 hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Reinhold Obermeyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Massachusetts

12-MAIDEN NAME OF MOTHER, Mary Elizabeth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) Father Obermeyer

(Address) 232 Highland Ave

15-

Filed 19?? Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct-20-27

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 19 27 to Oct 20 19 27

that I last saw h. alive on Oct - 20 19 27

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Immature Development

(Duration) 4 hrs mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Burton P Grace M. D.

19 (Address) 125 W Mt Vernon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Cem	Oct 21, 19 27

20-UNDERTAKER. ADDRESS

John C Miller 2435 E Monument

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26656

CERTIFICATE OF DEATH.

74-001

E 26656

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 Dover ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ball

(a) RESIDENCE NO. 739 Dover ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: William C Ball

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 56; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: Johns Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Elizabeth Md.

PARENTS

14 Informant: William C. Ball

(Address): 739 Dover st

15 Filed , 19 Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1927, to Oct 19, 1927, that I last saw h alive on Oct 19 1927 and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH was as follows:

Apoplexy -

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Physical Ex -

What test confirmed diagnosis?

(Signed) R. Garland Schmidt M.D.

Oct 19 1927 (Address) 1534 - Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery

DATE OF BURIAL: Oct 23 1927

20 UNDERTAKER: Edward Bryon

ADDRESS: 1681 orleans st

Spec.—1-12-23—M&T—500 Blks.

E 26657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 26657

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 528 (St.) Robt. (Ward) 14-20

2-FULL NAME Baby Maiden

(a) RESIDENCE NO. 528 (ST.) Robert St (WARD)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19-1927

7 AGE — Years | Months | Days: 1 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Britt Md

PARENTS

10 NAME OF FATHER Wilson Britten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katherine Stanley Maiden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Esther Britten

(Address) 528 Robert St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20 1927

17 I HEREBY CERTIFY, That I attended deceased from ..., 19 ..., to ..., 19 ...,

that I last saw h alive on ..., 19 ...

and that death occurred, on the date stated above, at ... m

The CAUSE OF DEATH* was as follows:

Premature Birth (7 mos.)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John R Britten, M. D.

19 (Address) 2124 Vit

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. | DATE OF BURIAL: 10-21 1927

20 UNDERTAKER: Geo. E. Gibson | ADDRESS: 1133 Myrtle Ave

OCT 21 1927 C. HAMPSON JONES

Spec.—1-12-23—M&T—500 Bks.

E 26658 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26658

CERTIFICATE OF DEATH.

1647

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 108 E. 25th ST., 12th WARD) 50

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Robinson Cole

(a) RESIDENCE NO. 108 E. 25th ST., 12th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of J. C. L. Cole

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1840

7 AGE: Years 87 | Months 2 | Days 5 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER Thos. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant J. C. L. Cole

(Address) 108 E. 25th St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 19 27

17

I HEREBY CERTIFY, That I attended deceased from 10/20/20 19 to 10/20/27 19

that I last saw h[illegible] alive on 10/20/27 19

and that death occurred, on the date stated above, at 2-30 P m.

The CAUSE OF DEATH* was as follows:

Old age.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) H. W. Gadd[illegible] M. D.

10/20/27 (Address) 321 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem. | DATE OF BURIAL: Oct 22 19 27

20 UNDERTAKER: Percy Hawkins | ADDRESS: [illegible]

OCT 22 1927 C. HAMPSON JONES, M.D.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26659
1-PLACE OF DEATH

CERTIFICATE OF DEATH

133 E 26659
REGISTERED NO.

City of BALTIMORE: (No. 3036 Elliott St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOSEPH GORNY,

(a) RESIDENCE NO. 3036 Elliott St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susanna Gorny,

6 DATE OF BIRTH (month, day, and year) Unknown, 1850.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	77			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None, pd
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland,

PARENTS
10 NAME OF FATHER Unknown,
11 BIRTHPLACE OF FATHER (City or town)
(State or country) Poland,
12 MAIDEN NAME OF MOTHER Unknown,
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland,

14 Informant Mrs. Susanna Gorny, (Wife)
(Address) 3036 Elliott Street

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Octob 19 1927

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1927, to October 19, 1927, that I last saw h.e alive on October 18, 1927, and that death occurred, on the date stated above, at 905 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia Paralysis of the heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atrophia cordis cystica pulmonum

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Principal symptoms.

(Signed) Joseph A. Blenkatt, M. D.
Oct 21, 1927 (Address) 308 S. Broadway Balto Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus — Date of Burial Oct 22 1927

20 UNDERTAKER M. J. Sadowski. — ADDRESS 905 S. Wolfe St.

OCT 21 1927 C. HAMPSON JONES

Spec.—1-1-27—M&T—500 Blks.

E 26660 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26660

CERTIFICATE OF DEATH. 5

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ella Bailey St., 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 700 N Edew

(a) RESIDENCE NO. 700 N Edew St.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1863

7 AGE Years 64 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot County.

12 MAIDEN NAME OF MOTHER Jane Sampson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Chester Co.

4 Informant Lillie Ellis

(Address) 245 Edward St.

5 Filed . 19 H. A. Cox Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 1 . 1927 . to Oct 20 . 1927 .

that I last saw he alive on Oct 19 . 1927 .

and that death occurred, on the date stated above, at 1 A' m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Diabetes Mellitus unknown

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Septicemia due to Abscess Scalp (duration) 2 wks mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis? R J Gosling

(Signed) . M. D.

Oct 21 1927 (Address) 1726 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashury Cemetery

DATE OF BURIAL Oct 03 1927

20 UNDERTAKER Jos. T. H. Rochester

ADDRESS 1413 Jefferson St.

Spec.—1-12-23—3,&T—500 Blks.

E 26661

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26661

CERTIFICATE OF DEATH.

7-13

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) West Baltimore General Hospital WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Rodgers

(a) RESIDENCE NO. 1629 Ashland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Sept 1-1903

8 AGE: Years 24 Months 1 Days If LESS than 1 day, hrs or min

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER Andrew Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Countess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co. Md.

Informant (Address)

Filed 1927 Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18 1927 to Oct. 20 1927.

that I last saw him alive on Oct. 20 1927

and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes no Date of

Was there an autopsy? yes Autopsy

What test confirmed diagnosis?

(Signed) Louis T. Lavy M. D.

20 1927 (Address) W. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetary

DATE OF BURIAL: Oct 23 1927

20 UNDERTAKER: Jos. T. H. Archester

ADDRESS: 1463 Hillsmon St

Cor.—12-9-25—A Co.—200 Bks.

E 26662 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 26662

CERTIFICATE OF DEATH.

199

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 11-15 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcella Hicks

(a) RESIDENCE NO. 129 E. Biddle St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Div.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr 27-1898

7 AGE: Years 29 Months 5 Days 23 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): in Store

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Ernest S. Dorsey

11 BIRTHPLACE OF FATHER (city or town): Canada

(State or country)

12 MAIDEN NAME OF MOTHER: H. Desmeules

13 BIRTHPLACE OF MOTHER (city or town): Canada

(State or country)

14 Informant (Address): Mrs. H. ~~Dorsey~~ Desjardins Buctouche, Canada

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis

Abortion

(duration) Self mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. Reily M. D.

(Coroner)

Oct. 22, 1929 (Address) 1639 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. State ~~Canada~~ 3-days & 2 wks

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem Date of Burial 10/24 1929

20 UNDERTAKER: Hart Simpers & Hurley ADDRESS: Fulton & Lafayette

Spec. -7-17-26—A Co.—200 Bks.

Lobenwein

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26663

CERTIFICATE OF DEATH

49

E 26663

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals 2-4 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lobenwein

(a) RESIDENCE NO. 1634 Aliceanna St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Flora Lobenwein

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 62 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER: John Lobenwein

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Regina

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs. Baker

(Address) 306 S. Broadway

15 Filed ..... 19 .....

Registrar

OCT 21 1927 C. HAMPSON FORD

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct. 21, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1927 to Oct 21, 1927

that I last saw him alive on Oct 20, 1927

and that death occurred, on the date stated above, at 12:15 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

Metastasis mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) H. Bayne M. D.

. 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: 1st Evangelical Cemetery — Date of Burial: Oct 24 1927

20 UNDERTAKER: H. Sander Sons — ADDRESS: 1710 Pleasant St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26664

CERTIFICATE OF DEATH.

E 26664

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital Ward)

2-FULL NAME John. C. Deckert

(a) RESIDENCE NO. 604 W. Hamburg Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Deckert

6 DATE OF BIRTH (month, day, and year): Oct 23 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	51	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Switch tender

(b) General nature of industry, business, or establishment in which employed (or employer): Operator

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: August Deckert

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Seitz

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Mrs. Eliz. Deckert

(Address) 604 W. Hamburg

15 Filed ....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 a 2 days from accidentally coming in contact with electric current

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock, burns by arm hand

(duration) yrs. mos. ds.

(Signed) W. J. Riley M. D.

(Coroner)

Oct. 29, 1927 (Address) 16 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial 10/31/27

20 UNDERTAKER: W. J. Richardson Sons ADDRESS Balto

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26665

CERTIFICATE OF DEATH

E 26665

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1932 Harlem Ave St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter T. Baggs

(a) RESIDENCE NO. 1932 Harlem Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose M Baggs

6 DATE OF BIRTH (month, day, and year): Aug 10 1861

7 AGE: Years 66 Months 2 Days 9 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Collector

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Talbot Co (State or country) Md

PARENTS

10 NAME OF FATHER: John Baggs

11 BIRTHPLACE OF FATHER (City or town): (State or country) Talbot Co Md

12 MAIDEN NAME OF MOTHER: Mary Burchenal

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Talbot Co Md

14 Informant: Walter M Baggs (Address) 1932 Harlem Ave

15 Filed 19 Registrar

C. H. THOMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Oct 19 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1927 to Oct 19 1927

that I last saw h alive on Oct 16 1927

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — Date of Burial: Oct 22 1927

20 UNDERTAKER: George F Smith — ADDRESS 1531 Harlem

Spec. 7-15-26 A Co. 200 Blks.

E 26666 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26666

CERTIFICATE OF DEATH

1-PLACE OF DEATH Univ Hospital REGISTERED NO.

City of BALTIMORE: (No. 15-63 St. Ward),

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Clampitt

(a) RESIDENCE NO. 4103 Boarman Ave St. Ward

(Usual place of abode) 4103 Boarman Ave (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	Colrd	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Katherine Clampitt

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
59				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER William H. Clampitt

11 BIRTHPLACE OF FATHER (City or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Emily Clark

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Katie E Clampitt

(Address) 4103 Boarman Ave

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1927, to Oct 19, 1927, that I last saw h[illegible] alive on Oct 19, 1927, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Acute Coronary Thrombosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Oct 14 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New Cathedral Cemetery	Oct 22 1927
20 UNDERTAKER	ADDRESS
Harry H Arrasmith	1201 Hedgewood Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26667

E 26667

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Powell

(a) RESIDENCE NO. Pratt St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years: 35 Months: Days: IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927: Oct. 19,

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1927 to Oct 19, 1927, that I last saw h[illegible] alive on Oct. 19, 1927, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) 6 mos.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? Yes Date of 11-12-27

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Section

(Signed) [illegible], M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19

20 UNDERTAKER | ADDRESS

1820

UNIVERSITY OF MARYLAND
OCT 29 1927
HARRISON-JONES MEDICAL LIBRARY
Commissioner of Health

Spec.—1-12-23—M&T—500 Bks.

E 26668

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26668

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1541 Pennsylvania ST. 14-W (WARD)

2-FULL NAME George J. Hook

(a) RESIDENCE No. 1541 Pennsylvania ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 6 - 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49	4	13	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner, Copper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Henry Hook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Ring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mary Hook

(Address) 1541 Pennsylvania Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1927, to Oct 19, 1927, that I last saw h[illegible] alive on Oct 19, 1927, and that death occurred, on the date stated above, at 12 45 A m

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Chas. P. Claytor M. D.

Oct X, 1927 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 22 27
20 UNDERTAKER	ADDRESS
James B Lyons	1324 Eutaw Pl

07 21 1927 C HAMILTON JONES

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26669 E 26669

CERTIFICATE OF DEATH

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2817 Hudson ST., 11-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bartholomew Kane

(a) RESIDENCE NO. 2817 Hudson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Budget Kane

6 DATE OF BIRTH (month, day, and year) aug 15 1855

7 AGE Years 72 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Fairgrall Co

(c) Name of employer Co. Laborer

9 BIRTHPLACE (city or town) Ireland (State or country)

PARENTS

10 NAME OF FATHER Anthony Kane

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Ellen Keeley

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Budget Kane (Address) 2817 Hudson St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to Oct 19, 1927, that I last saw h in alive on Oct 19, 1927, and that death occurred, on the date stated above, at 2 PM, m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) acute Congestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. L. Burke, M. D.

1927 (Address) 8042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 10/22/1927

20 UNDERTAKER J. A. Moran

ADDRESS 309 E Balto St

VOET C. SHAMPSON JONES, M. D.

Part

OK F

Spec.—1-12-23—M&T—500 Blks.

E 26670

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 26670

CERTIFICATE OF DEATH.

REGISTERED NO. 702992 E

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1- Norwood Place 27-49 WARD)

2-FULL NAME Laura Adams Drury

(a) RESIDENCE NO. 1- Norwood Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced (or) WIFE of Edward I. Drury

6 DATE OF BIRTH (month, day, and year) April 1- 1857

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
70	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Att's Counsel

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Maryland

10 NAME OF FATHER Wm H. Adams

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) City Maryland

12 MAIDEN NAME OF MOTHER Isabella King

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) City Maryland

14 Informant Edward I. Drury

(Address) 2919 St Paul Street

Filed Oct 24 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st 1927 to Oct 21st 1927, that I last saw h alive on Oct. 20th 1927 and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Infl Endocarditis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferies Busk, M. D.

10/24 1927 (Address) 110 S. Club Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Oct 22 1927

20 UNDERTAKER William Cook

ADDRESS 502 E Howard

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26671

CERTIFICATE OF DEATH

89 E 26671

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3908 Edmondson Ave St., 16-71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Boyd McCatee

(a) RESIDENCE NO. 3908 Edmondson Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 23rd 1863

7 AGE — Years: 64 — Months: 4 — Days: 21

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Private Detective

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Pa

(State or country)

PARENTS

10 NAME OF FATHER: Walter B. McCatee

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Hagerstown Md

12 MAIDEN NAME OF MOTHER: Rachel McCullough

13 BIRTHPLACE OF MOTHER (City or town):

(State or country): Pa

14 Informant: Mrs Emma Sutton

(Address): 515 Park Ave

15 Filed ..... 19 .....

HENRY C. HAWKINS, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 21 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 1927, to Oct 21st, 1927, that I last saw him alive on Oct 20th, 1927, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Angina Pectoris Myocarditis

(duration) Since yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Acute Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carey B. Hammett, M. D.

19 Date of Burial: Oct 24 19 27

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

20 UNDERTAKER: Henry Jenkins Sons Co

ADDRESS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Cor.—12-9-25—A Co.—200 Bks.

E 26672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 E 26672

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 3700 Cedardale St., 15-62 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. C. Deale

(a) RESIDENCE NO. 3700 Cedardale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1775

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Dr.

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Navy

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis

(State or country) Md.

PARENTS

10 NAME OF FATHER James Deale

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Laura Gorsuch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant James Deale

(Address) 3700 Cedardale Ave

15 Filed 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed: [illegible] M. D.

(Coroner)

Oct 22, 19 27 (Address) 25 Fountain

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL National

Date of Burial Oct 25 192 7

20 UNDERTAKER Wendell Duffy

ADDRESS 3718 Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26673

CERTIFICATE OF DEATH.

74-001 E 26673

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1819 E. Eager St St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Kozak

(a) RESIDENCE NO. 1819 E. Eager St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Kozak

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Slifka

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Vovak

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bohemia

14 Informant Joseph Kozak

(Address) 1819 E. Eager St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20-27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. R. Collins M. D.
(Coroner)

10/21/27 (Address) 500 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial 19

20 UNDERTAKER Frank A. Goodson ADDRESS 1906 Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 26674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26674

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 S Paca ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Stallings

(a) RESIDENCE No. 1000 S Paca. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 13th 1878

7 AGE: Years 49 Months 8 Days 7 If LESS than 1 day, hrs. ... or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER William Stallings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary E Cavanaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

PARENTS

14 Informant Mrs William Geary

(Address) 1000 S Paca St

15 Filed ..., 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29-1927

17 I HEREBY CERTIFY, That I attended deceased from 8/20, 1927, to 10/29, 1927, that I last saw h[illegible] alive on 10/20/27, 19 ..., and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Hypertension

Chronic Nephritis

(duration) unknown yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward J. Geary, M. D.

(Address) 712 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 10-31-1927

20 UNDERTAKER: Bernard C Hank — ADDRESS: 1000 Paca St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26675

CERTIFICATE OF DEATH.

90 E 26675

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 154 W. Cross St. 43-31 St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Stange. Sr.

(a) RESIDENCE NO. 154 W. Cross St. St.____ Ward____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 60 yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If ~~XXXXX~~ widowed, ~~XXXXXX~~ HUSBAND of ~~XXXXXX~~: Mafy A. Stange.

6 DATE OF BIRTH (month, day, and year) February 18, 1856.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	71	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cooper.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)____ (State or country) Germany.

PARENTS

10 NAME OF FATHER David Stange.

11 BIRTHPLACE OF FATHER (city or town)____ (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)____ (State or country) Germany.

14 Informant Anna Stange. (daughter)
(Address) 154 W. Cross St.

15 Filed____ 19____ ____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) Otto M. Hemraidt M. D. (Coroner)

10/21 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?____

Former or usual residence____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross AA Co. Date of Burial: 10-24-1927

20 UNDERTAKER: C. H. Hanke 115 E. Lexington St. ADDRESS

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26676

CERTIFICATE OF DEATH

E 26676

1-PLACE OF DEATH Univ Hospital

REGISTERED NO. 70-64

City of BALTIMORE: (No. _____ St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norma Edwards

(a) RESIDENCE NO. 2106 W Saratoga St. St. _____ Ward Only VA.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. _____ mos. 18 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 1923

7 AGE: Years 4 1/2 Months 6 Days _____ If LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER James Edwards

11 BIRTHPLACE OF FATHER (City or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Mary Kellerman

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Mary Edwards

(Address) 2106 W Saratoga St

15 Filed _____ 19 _____ _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 2 1927 to Oct 20 1927

that I last saw her alive on Oct 20 1927

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac entarrasment &

failure

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Syphilis of aorta &

Aortic valve insufficiency

(doration) yrs. 6 mos. ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) _____, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cityp Va Date of Burial Oct 22 1927

20 UNDERTAKER George Schmidt ADDRESS 2109 Eutaw

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26677

E 26677

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hosp St. 17-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Doris May Boston

(a) RESIDENCE NO. Rockburn P.O. Elkridge Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 48 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9-1927

7 AGE Years Months Days 11 wks 2 12

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rockburn P.O. Elkridge Md (State or country)

PARENTS

10 NAME OF FATHER Raymond Boston

11 BIRTHPLACE OF FATHER (City or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Carrie Partridge

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mother (Address) (Same as above)

15 Filed ..... 19 ..... Registrar

Per .....

C. HAMPTON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1927, to Oct 21, 1927, that I last saw her alive on Oct 21, 1927, and that death occurred, on the date stated above, at 6.55 a.m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. mos 7 wks 2 ds.

CONTRIBUTORY (Secondary) Prematurity & Malnutrition

(duration) yrs. mos 11 wks ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William R. Swarthout, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — Date of Burial: Oct 22nd, 1927

20 UNDERTAKER: John J. Bowen & Son — ADDRESS: 901 Hollins St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26678

CERTIFICATE OF DEATH.

E 26678

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 McCulloh ST. 14-20 WARD)

2-FULL NAME Laura Green

(a) RESIDENCE No. 1627 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 57; Months —; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Benj. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Depree

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Marie L Oliver (Address) 1627 McCulloh St

15 Filed OCT 22 1927, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 19 27, to Oct 20, 19 27, that I last saw her alive on Oct 20, 19 27, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Old Age

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and Symptoms

(Signed) Charles H. Hooker, M. D.

(Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Oct. 23, 19 27

20 UNDERTAKER: John N. Toadvine

ADDRESS 1027 Cumberland

Spec.—12 9 25—A Co.—200 Bks.

E 26679

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26679

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hosp

City of BALTIMORE: (No. ~~639 Lancaster~~ 2-4 St. _____ Ward)

2-FULL NAME Anton Nesterek

(a) RESIDENCE NO. 1639 Lancaster St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ____ mos. ____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 20 yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) City of Balto

(c) Name of employer

9 BIRTHPLACE (city or town) Russia Poland

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Russia Poland

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia Poland

(State or country)

14 Informant Mrs Mikalaj Gwiazdowski (Address) 258½ E Pallas St

15 Filed _____, 19__ HAMPSON JONES _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14/27 19

17 I HEREBY CERTIFY, That I attended deceased from 10/14/ 1927, to 10/19, 1927, that I last saw h~~im~~er alive on 10/19 1927, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

1. Carcinoma of Stomach
2. Intestinal Obstruction

(duration) ~~4~~ 2 mos. ____ ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

Work, (duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 10/19/27

Was there an autopsy? Yes

What test confirmed diagnosis? Pathologist

(Signed) R Schuman, M. D.

Oct 20, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Russian Independ Stoney Run A A Co — Date of Burial Oct 22 1927

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank St

Spec.-7-17-26—A Co.—200 Bks.

E 26680

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26680

CERTIFICATE OF DEATH

32

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St. Joseph's Hospital St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis E. Gadden Jr

(a) RESIDENCE NO. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 16, 1918

7 AGE	Years	Months	Days
	9	0	5

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Francis E. Gadden Jr

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Mary I. Lurick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Francis E. Gadden Sr.

(Address) 524 S. Bentalou St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Oct. 22

17 I HEREBY CERTIFY, That I attended deceased from , 19, to , 19,

that I last saw h alive on , 19,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Lawrence Fahrney, M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Cathedral cem.	Oct. 24, 1927
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	14 N. Eutaw St

OCT 22 1927

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 26681

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26681

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 728 Grindall Court. St. 42-31 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nettie Selman.(C)

(a) RESIDENCE NO. 728 Grindall Court. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37	_____		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant John F. Dorsey.(C)

(Address) 728 Grindall Court.

15 Filed _____, 19__ Registrar Harris

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of an Aortic Aneurism.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Otto Reinhardt M. D.

(Coroner)

10/21 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial 10/22/27

20 UNDERTAKER Samuel Hemsley ADDRESS 2[illegible] W Balto

Spec.—1-12-23—M&T—500 Blks

E 26682

E 26682 HEALTH DEPARTMENT—CITY OF BALTIMORE

205

128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST., 6-4 WARD)

CITY OF BALTIMORE: (No.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rena Young

(a) RESIDENCE NO. 1605 Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Col-

5 Single, Married, Widowed, or ~~Divorced~~, (write the word)

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 1895

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Washwoman

(b) General nature of industry, business, or establishment in which employed (or employer): 010

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Washington, D.C

10 NAME OF FATHER: Howard Irving

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington, D.C

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant: Johns Hopkins Hospital

(Address)

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1927

17 I HEREBY CERTIFY, That I attended deceased from August 13, 1927, to October 20, 1927, that I last saw her alive on Oct. 20, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

Uraemia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Christopher Johnston, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery — DATE OF BURIAL: Oct 23 1927

20 UNDERTAKER: Edward Bryan — ADDRESS: 1631 Orleans St

OCT 22 1927 C. HAMPSON JONES

Spec-7-1926-C-0-200 Bks.

E 26683

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26683

CERTIFICATE OF DEATH

100-00

1-PLACE OF DEATH

REGISTERED NO. _____

City of BALTIMORE: (No. 114 S. Broadway St., 3-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia E. Eberly

(a) RESIDENCE NO. 114 S. Broadway St. Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel G. Eberly

6 DATE OF BIRTH (month, day, and year) July 22, 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	69	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER George Voyce

11 BIRTHPLACE OF FATHER (City or town) _____
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Rosa Brotzell

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Baltimore, Md.

14 Informant Alva W. Voyce
(Address) 1413 Poplar Grove St.

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 19 27, to Oct 20, 19 27, that I last saw h[illegible] alive on Oct 20, 19 27, and that death occurred, on the date stated above, at 9.15 p. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) _____ yrs. _____ mos. 14 da.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) ✓ yrs. ✓ mos. ✓ da.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) John A. Ahalard, M. D.

10/22, 19 27 (Address) 1219 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Lorraine Cemetery	Oct 24 19 27
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

pec.—1-12-23—M&T—500 Bks.

E 26684 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 24-34 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C Byrd

(a) RESIDENCE NO. 302 Rundale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~: Single

6 If married, widowed, or divorced HUSBAND of or) WIFE of

DATE OF BIRTH (month, day, and year) 4-15-60

AGE	Years	Months	Days	If LESS than 1 day, hrs or mnts.
	67	1	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md Maryland

10 NAME OF FATHER C. J. Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Amanda Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant JOHNS HOPKINS HOSPITAL

(Address)

Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1927

17 I HEREBY CERTIFY, That I attended deceased from September 30 1927 to October 20 1927, that I last saw him alive on Oct. 20 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-5-27

Was there an autopsy? Yes

What test confirmed diagnosis? Yes Autopsy

(Signed) Morris Hayes M. D.

10-4, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL Oct 24 1927

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Spec.—1-12-23—M&T—500 Blks.

E 26685 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26685

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1554 Bruce ST. 14-70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Brown Collins

(a) RESIDENCE No. 1554 Bruce ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

Female

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1871

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	36			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Geo Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hettie Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Hettie Brown

(Address) 1564 Bruce St

Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 4, 1927, to Oct 20, 1927, that I last saw her alive on Oct 14, 1927 and that death occurred, on the date stated above, at 5.45 A m

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs 1 mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter , M. D.

19th, 1927 (Address) 1215 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	10/22 1927
20 UNDERTAKER Deming & Evans	ADDRESS 116 Park Ave

Succ.—1-12-23—M&T—500 Blks.

E 26686

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26686

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3 Warner (ST.) 25th (WARD) 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Downey

(a) RESIDENCE No. 3 Warner ST. 25th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Ozzle

6 DATE OF BIRTH (month, day, and year) July 4, 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	3	17	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Brick yard.

(c) Name of employer: Wagner Brick Co.

8 BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: James Downey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

Informant: Susan Parker.

(Address) 3 Warner St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Oct 21, 1927.

that I last saw h~~im~~ alive on Oct 20, 1927

and that death occurred, on the date stated above, at 6:15 ~~P~~ m

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No ~

What test confirmed diagnosis? ~

(Signed) H. Lawrence Wheeler, M. D.

Oct 27, 1927 (Address) Lakeland Lansdowne Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Oct 22 1927

20 UNDERTAKER: Hunt Easton

ADDRESS 916 Pa Ave

Cor.—12-9-25—A Co.—200 Bks.

E 26687 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26687

188-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 11-24 Ward)

2-FULL NAME Plaise Lark

(a) RESIDENCE NO. 2034 W. Hoffman St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5y yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1844 – 1892

7 AGE: Years 33 Months 33 Days 33 yrs

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) S. C.

(State or country)

PARENTS

10 NAME OF FATHER Ben Clark.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S. C.

12 MAIDEN NAME OF MOTHER Della Shaw

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S. C.

14 Informant Sister Address 2034 W. Hoffman St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. of Skull & Shock

Struck by R.R. Engine

(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

(Signed) Coroner M. D.

, 1927 (Address) 1659 Bruce

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carrigal U. C. Date of Burial Oct 15 1927

20 UNDERTAKER Noland Easton ADDRESS 916 Mus

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26688

CERTIFICATE OF DEATH.

129 E 26688

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 2123 Clifton Ave ST. 15 61 WARD)

2-FULL NAME Emma Mueller

(a) RESIDENCE NO. 2123 Clifton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Henry John Mueller

6 DATE OF BIRTH (month, day, and year): May 21 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: Retired

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Frederick Palm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Minnie Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Mrs Geo. A. Gilmore

(Address) 2122 Clifton Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21, 1927

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1927, to Oct 21, 1927,

that I last saw h[illegible] alive on Oct 21, 1927,

and that death occurred, on the date stated above, at 3:20 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

First Stroke on 1920

Second " Oct 21/27 - 8 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis and Mitral Regurgitation

(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home about 2 years

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. A. Duvall, M. D.

, 19 (Address) 819 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 10/24/1927

20 UNDERTAKER: Geo. Weber & Son

ADDRESS: 2503 Edmondson Ave

Cor.—12-9-25—A Co.—200 Bks.

E 26689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7001

E 26689

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 922 N. Eutaw St. 11-24 Ward)

2-FULL NAME Dennis Payne

(a) RESIDENCE NO. 922 N. Eutaw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1847

7 AGE: Years about 60 Months Days

If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town)

(State or country) Va

10 NAME OF FATHER Louis Payne

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Roberts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs. R. A. Elliott

(Address) 1725 Ashland ave

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Other causes

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial Oct. 22 1927

20 UNDERTAKER: Mrs. R. A. Elliott ADDRESS 1725 Ashland ave

Spec.—1-10-21—M&T—1500 Blks.

E 26690 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26690

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH 1036 N. Wolfe Street

CITY OF BALTIMORE: (No. 1036 ST., N. Wolfe WARD 7-13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edward Stanley

(a) RESIDENCE No. 1036 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	cd	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louisa Stanley

6 DATE OF BIRTH (month, day, and year) Uncertain 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or .... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Gen'l

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. E. Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Uncertain

14 Informant (Address) Chas. Stanley 1036 N. Wolfe st.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10—18 1927

17

I HEREBY CERTIFY, That I attended deceased from 10—2-27, 19 . to 10—18-27, 19 .

that I last saw h— alive on 10—16—27, 19

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Hypertension

Acute Cardiac Dilatation

Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. B. Butler, M. D.

, 19 (Address) 925 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery — DATE OF BURIAL Oct. 20 1927

20 UNDERTAKER Mrs. W. H. Elliott — ADDRESS 1725 Ashland Ave.

pec.—1-12-23—M&T—500 Bks.

E 26691 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26691

2075

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Bailey

(a) RESIDENCE No. 9th St. Sparrows Point ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Col-

5 Single, Married, Widowed or Divorced, (write the word): Baby

If married, widowed, or divorced
HUSBAND of
or) WIFE of

DATE OF BIRTH (month, day, and year) 11-30-26

AGE	Years	Months	Days	If LESS than 1 day, hrs. or.....min.
	1 Months	10	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Daingerfield Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lilly Tapple

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant

(Address) JOHNS HOPKINS HOSPITAL

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct-14 .1927. to Oct. 21 .1927.

that I last saw h[illegible] alive on Oct-21 .1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia — 9 days

Pneumococcus Meningitis 12 hours

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar Puncture

(Signed) J. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Smith Field Va — DATE OF BURIAL: Oct 22 1927

20 UNDERTAKER: Edward Bryan — ADDRESS 1691 Orleans st

Spec.—1-12 23—M&T—500 Bks.

26692-3

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSP.

CITY OF BALTIMORE: (No. ... St., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DAN CATHRENO

(a) RESIDENCE NO. Star City, W. Va ... ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Anna

DATE OF BIRTH (month, day, and year) 1892

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bones

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER John Cathreno

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Agnes Palaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Fiorde JOHNS HOPKINS HOSP.

(Address)

Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15 , 1927 , to Oct. 22 , 1927.

that I last saw h[illegible] alive on Oct. 22 , 1927.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

carcinoma of colon

(duration) ... yrs. 6 mos ... ds

CONTRIBUTORY (Secondary) intestinal obstruction

(duration) ... yrs. ... mos. 3 wks.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of 3 mos. ago and 10-18-27

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) I. Ridgeway Trimble M. D.

Oct 22 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Star City W Va — DATE OF BURIAL 10/22/27

20 UNDERTAKER Joseph Owens — ADDRESS 22 Bway

OCT 22 1927 C. HUDSON JONES, M.D.

Spec.—13-8 25—A Co.—200 Bks.

E 26693 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 26693

161-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital 4 75 Ward)

2-FULL NAME Baby Boy Campbell

(a) RESIDENCE NO. 1720 N. Homland St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 10-21-27

7 AGE — Years | Months | Days | IF LESS than 1 day.....hrs. 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER John J. Campbell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Hookstown Pa

12 MAIDEN NAME OF MOTHER Agnes Flecka

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Portage Pa

14 Informant John Joseph Campbell

(Address) 1720 N. Homland St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 10-21-27

17 I HEREBY CERTIFY, That I attended deceased from 10-21, 19 27, to 10-21-, 19 27, that I last saw h in alive on 10-21, 19 27, and that death occurred, on the date stated above, at 6.35 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum (premature 6 mos)

(duration) .....yrs. .....mos. .....ds.

CONTRIBITORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. K. Deady Jaeca, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: 10-22-1927

20 UNDERTAKER: Geo A Harley — ADDRESS: 800 W Fayette

Spec.—7-17-26—A Co.—200 Bks.

E 26694

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-00

E 26694

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Josephs Hospital.

REGISTERED NO.

City of BALTIMORE: (No. Caroline & Oliver St. 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby - Verzi.

(a) RESIDENCE NO. 117 E. Pleasant St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	white.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 16 - 27

7 AGE Years Months Days IF LESS than 1 day 5 hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George Gregory Verzi

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Baltimore. Md.

12 MAIDEN NAME OF MOTHER Grace J. Collins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant
(Address)

15 Filed . 19
Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Oct. 16 - 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1927, to Oct 16, 1927
that I last saw her alive on Oct 16, 1927
and that death occurred, on the date stated above, at 3:00 p.m.
The CAUSE OF DEATH* was as follows:

Premature 5½ months.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical.

(Signed) [illegible] M. D.
. 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

C. HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26695
1-PLACE OF DEATH

45

E 26695
REGISTERED NO.

City of BALTIMORE: (No. St Agnes Hospital 11-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Emily Magruder

(a) RESIDENCE NO. 417 N. Carrollton Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20, 1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	6 5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) City.
(State or country)

PARENTS

10 NAME OF FATHER Isaac Magruder

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Cath. Floyd

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md

14 Informant Mrs. Kate Umcheater
(Address) St Timothy Lane Catons

15 Filed....., 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21-27 19

17 I HEREBY CERTIFY, That I attended deceased from 6-10, 1927, to 10-21-, 1927
that I last saw her alive on 10-21, 1927
and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Sigmoid
- Inoperable

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Terminal Generalized Carcinomatosis

(duration) .....yrs. .....mos. .....ds.

Is Where was disease contracted
If not at place of death? at home
Did an operation precede death? yes. Date of 6-25-27.
Was there an autopsy? no.
What test confirmed diagnosis? Surgical + clinical

(Signed) A. J. Knapp, M. D.
10-21, 1927. (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Mt Western Cem Oct 24 1927

20 UNDERTAKER — ADDRESS
George J Smith Hollins

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26696

CERTIFICATE OF DEATH.

X 117 E 26696

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 75-72 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Buxton

(a) RESIDENCE NO. Relay Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 5, 1906

7 AGE: Years 21 Months 1 Days 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): 09

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Brook Buxton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Luetta Yarbrough

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) West Virginia

14 Informant Margaret Buxton

(Address) Relay Md

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10-21-27

17 I HEREBY CERTIFY, That I attended deceased from 10-20-1927 to 10-21, 1927, that I last saw h alive on 10-21, 1927, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10/20/27

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. L. Dadaglinecca, M. D.

, 19 (Address) St Agnes' Hosp'l.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Oct 24 1927

20 UNDERTAKER: George J Smith ADDRESS 1532 Hollins

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26697

CERTIFICATE OF DEATH

90 E 26697

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 416 Myrtle Ave St. 4-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Johnson

(a) RESIDENCE NO. 416 Myrtle Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 5 - 1863

7 AGE — Years: 64 Months: 6 Days: 14 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): West River

(State or country): Md

PARENTS

10 NAME OF FATHER: John J. Turner

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Julia Mack

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Mrs. E. Johnson

(Address) 416 Myrtle Ave.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct - 19. 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct - 1 - 27, 19.., to Oct 19, 19 27.

that I last saw h.. alive on Oct 19, 19 27

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

2 yr

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ex Hemorrhage

(duration) yrs. mos 10 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S B Hunter M. D.

(Address) 1413 Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem Date of Burial Oct 22 27

20 UNDERTAKER: Frank Kinsley ADDRESS Belle

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26698

CERTIFICATE OF DEATH.

45 E 26698

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 14-20 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Louise Weiner

(a) RESIDENCE NO. 1619 Eutaw Pl. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1855

7 AGE: 72 Years (68 - about) Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School teacher

(b) General nature of Industry, business, or establishment in which employed (or employer): Educational

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Morris Weiner

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Rosalie —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Miss. Blanche Adler

(Address) Riviera Apts.

15 Filed....., 19.....

Registrar

OCT 22 1927 C. LYMPSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 21, 1927

17

I HEREBY CERTIFY, That I attended deceased from August 10, 1927, to October 21, 1927, that I last saw h.. alive on October 21, 1927, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of recto-sigmoid

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Metastases

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. Edmund Levin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 BURIAL, CREMATION OR REMOVAL: Interred and buried in Hartland London Park Cem. Date of Burial 10/24/1927

20 UNDERTAKER: Kloid Londheim ADDRESS 115-20 W. Mt. Royal Ave.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26699 — 94E 26699

1-PLACE OF DEATH: Eutaw Place & Lake Drive.

REGISTERED NO.

City of BALTIMORE: (No. Emersonian Apts. 5 D. St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Maurice Wyman.

(a) RESIDENCE NO. Emersonian Apts. 5 D. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stella E. Wyman.

6 DATE OF BIRTH (month, day, and year) Oct. 9th. 1863.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Store Prop.

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) Alexandria, (State or country) Va.

PARENTS

10 NAME OF FATHER Emanuel Wyman

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Block

13 BIRTHPLACE OF MOTHER (city or town) Belair, (State or country) Md.

14 Informant Mr. Henry Wyman, (Address) Emersonain Apts.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 7. 1922. to Oct 20. 1927. that I last saw h[illegible] alive on Oct 20. 1927. and that death occurred, on the date stated above, at 9.30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger M. D.

Oct 21. 1927 (Address) 1207 Eutaw Place.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	Date of Burial
Baltimore Hebrew Cem.	10/23/ 1927
20 UNDERTAKER: David Sondheim	ADDRESS: 115-20 W. Mt. Royal Ave.

OCT 22 1927 C. HAMBURGER M.D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26700

CERTIFICATE OF DEATH.

Md. Wm Hanitty 2225 St. Paul St

49

E 26700

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2406 Hudson ST., V3 WARD)

2-FULL NAME Marie A. Canoles.

(a) RESIDENCE NO. 2406 Hudson ST., 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 5 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Canoles

6 DATE OF BIRTH (month, day, and year): April 28th 1900

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
27	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John E. Mooney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Laura V. McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Laura V. Mooney (Address): 2406 Hudson St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1926, to Oct 20, 1927, that I last saw h[er] alive on Oct 19, 1927, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Gliona of the Cerebellum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Increased intra Cranial Pressure (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 1926

Was there an autopsy? no

What test confirmed diagnosis? Operation & Clinical

(Signed) Chas R. Draughon, M. D.

(Address) 2225 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Oct. 24th 1927

20 UNDERTAKER: Lilly & Siler

ADDRESS: 4032 Wash. Blvd

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26701

CERTIFICATE OF DEATH

90 E 26701

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3505 Leverton Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Kopanski Sr.

(a) RESIDENCE NO. 3505 Leverton Ave St. 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S. if of foreign birth? 43 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Kopanski.

6 DATE OF BIRTH (month, day, and year): May 12th 1858

7 AGE — Years: 69 Months: 5 Days: 8

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Brewer

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Andrew Kopanski

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Frances Kopanski Wife

(Address): 3505 Leverton St.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 20th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 2-, 19.., to Oct 20, 19.., that I last saw h.. alive on Oct 20, 192.., and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): none

..... (duration) ..... yrs. ..... mos. ..... d..

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eduard [illegible] M. D.

Oct 19 (Address) 1706 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — Date of Burial: Oct. 24th 1927

20 UNDERTAKER: Lilly + Zeiler — ADDRESS: 403 S. Wood

Very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 26702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 26702

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 7-4 Ward)

2-FULL NAME Mary Small

(a) RESIDENCE NO. 1709 E Pratt St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wolf

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Pomeranty

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Bluma

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Benj Small

(Address) 1351 Hendrick Rd.

15 Filed _____, 19__ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death by Fever on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. 1 ds.

Oct 22/27 Signed G O Faded M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Arbor Hill Memorial Park 10/13/1927

20 UNDERTAKER Hof Funeral Home ADDRESS 1127 E Baltimore St

Spec.—1-12-23—M&T—500 Blks.

E 26703

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26703

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary 1951 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Neumann

(a) RESIDENCE No. 608 Winans Way ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of (Anna C (nee Jaudte))

DATE OF BIRTH (month, day, and year) Dec 10. 1872.

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54	10	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oil Business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer O+S

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Carl Neumann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Mrs. Wm. Neumann 608 Winans Way

Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1927

17

I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1927, to Oct 21, 1927, that I last saw him alive on Oct. 20, 1927 and that death occurred, on the date stated above, at 7 20 a m.

The CAUSE OF DEATH* was as follows:

Intrathoracic Tumor (type unknown)

(duration) 2 yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray & Clinical Exam.

(Signed) George B Breed, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudone (Cemetery

DATE OF BURIAL Oct 24 19 27

20 UNDERTAKER Harry H Nitzke

ADDRESS 1531 W Lanvale St

Spec.—1-12-23—M&T—500 Bks.

E 26704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89

E 26704

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 213 S. Eden St. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Tucker

(a) RESIDENCE No. 213 S. Eden St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Tucker

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 74 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Nathan Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Yetta Tucker

(Address) 213 S. Eden St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21 19 27

17 I HEREBY CERTIFY, That I attended deceased from April 18, 19 27, to Oct 21, 19 27, that I last saw her alive on 10/21, 19 27, and that death occurred, on the date stated above, at 4:20 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris, Mayo

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) David Miller, M. D.

10/21, 19 27 (Address) 1700 Edwards

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon

DATE OF BURIAL: 10/23 19 27

20 UNDERTAKER: Jack Levin

ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 26705

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26705

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 E. Baltimore St. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Morgolis

(a) RESIDENCE NO. 1714 E Baltimore St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced (or) WIFE of: Sarah Morgolis

7 DATE OF BIRTH (month, day, and year): Aug 1853

8 AGE: Years 74 | Months — | Days — | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 20 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927, to Oct 20, 1927, that I last saw him alive on Oct. 20, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel B. Wolfe, M. D.

, 19 (Address) 16 Irvine Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herron Rd.

DATE OF BURIAL: 10/23/19 27

20 UNDERTAKER: Hutchins

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

E 26706 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26706

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 E. Baltimore ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Goldberg

(a) RESIDENCE NO. 1703 E Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Esther Goldberg

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 86; Months —; Days —; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Levis 1437 E Baltimore St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1927, to Oct. 21, 1927, that I last saw h m alive on Oct. 21, 1927, and that death occurred, on the date stated above, at 4 05 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac Friedman, M. D.

10/22 1927 (Address) 1078 N Bentalou st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nelson Rosedale — DATE OF BURIAL 10/23/27

20 UNDERTAKER: Jack Levis 1437 E Balto St — ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26707

CERTIFICATE OF DEATH.

131 E 26707

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) City Hospital (St.) (Ward)

2-FULL NAME Estimain Jones

(a) RESIDENCE NO. 244 Pine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1900

7 AGE: Years 27 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

PARENTS

14 Informant Fannie Adams

(Address) 824 N Front St

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1927

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Autopsy (Inquest, autopsy or Inquiry.)

Personal and from the evidence obtained by said Autopsy (Coroner, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Cystitis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Foreign Body

(duration) ..... yrs. ..... mos. 1 ds.

Oct 21 1927 (Signed) C C Glades M. D.

19 (Address) 143 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial Oct 23 19 27

20 UNDERTAKER Bennett & Stansbury ADDRESS 578 McCulloh

APH

Spec.—1-10-21—M&T—1500 Bks.

26708 HEALTH DEPARTMENT—CITY OF BALTIMORE 26708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Elrita Ave ST. 25-12 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Koreder

(a) RESIDENCE NO. 2500 Elrita Ave ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. [redacted] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Koreder

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Wm Koreder (Address) 2500 Elrita Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1927

17 I HEREBY CERTIFY, That I attended deceased from ~~Oct 8~~ , 1927, to Oct 21, 1927, that I last saw her alive on Oct 20, 1927, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Cerebral Hemorrhage with Paralysis

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Gerd. M. Kieffer, M. D.

Oct 23, 1927 (Address) 2326 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lauden Park Cemetery Chas B. Kirchhausen

DATE OF BURIAL Oct 24 1927

20 UNDERTAKER London Park

ADDRESS 637 S. Paca

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26709

CERTIFICATE OF DEATH

E 26709

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. 4-30 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Thornton

(a) RESIDENCE NO. Lutherville Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Thornton

6 DATE OF BIRTH (month, day, and year) Apr 10. 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	42	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Edward Meredith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Alice Meredith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant George Thornton

(Address) Lutherville Md.

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20 19 27

17 I HEREBY CERTIFY, That I attended deceased from 10/8, 19 27, to 10/20, 19 27, that I last saw her alive on 10/20, 19 27, and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with hypertension Cardio vascular disease unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fibroids of uterus with hemorrhage and pyelitis (duration) unknown yrs. mos. ds.

18 Where was disease contracted

If not at places of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) E. L. Tuohy, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial 10/23 1927

20 UNDERTAKER J. W. Johnson ADDRESS 1234 Eutaw St

pec.—1-12-23—M&T—500 Bks.

E 26710

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26710

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard IPSARO

(a) RESIDENCE NO. 1910 East Eagle St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Orenta IPSARO

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Cosimo IPSARO

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Carmella

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant JOHNS HOPKINS HOSPITAL (Address)

Filed Oct 24 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct-19, 1927, to Oct 22, 1927, that I last saw h[illegible] alive on Oct-22, 1927, and that death occurred, on the date stated above, at 2 30 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency, broncho-pneumonia.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema, arteriosclerosis, apical TBC. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E C Jones, M. D.

10/24 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Oct 24 1927

20 UNDERTAKER Grant Croxton — ADDRESS Woodland

Cor.—12-9-25—A Co.—200 Bks.

E 26711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

No. E 26711

REGISTERED NO. 112

1-PLACE OF DEATH

City of BALTIMORE: (No. 746 Redwood St. 4-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Missie Watson

(a) RESIDENCE NO. 746 Redwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Watson

6 DATE OF BIRTH (month, day, and year): 1900

7 AGE — Years: 27 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Windsor

(State or country): N. C.

PARENTS

10 NAME OF FATHER: Peter Casey

11 BIRTHPLACE OF FATHER (city or town)

(State or country): N. C.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Albert Watson

(Address): 746 Redwood St

15 Filed ..... 19 ..... (CLAUDE C. JAMESON, JOHNS, M. D.) Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

St Vitus Dance

(duration) — yrs. — mos. 4 hrs

CONTRIBUTORY (secondary) Chronic Nephritis (duration) — yrs. — mos. 4 hrs

Oct 20 (Signed) Geo Claude Blake M. D.

, 19 (Coroner) (Address) 143 N Pine way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion cy — Date of Burial: Oct 23 19 27

20 UNDERTAKER: Leonard Whalen — ADDRESS: 307 Mulberry

Spec.—1-12-23—M&T—500 Blks.

E 26712 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26712

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 N. Ellwood av ST. 6-11 WARD)

2-FULL NAME Coleman Connelly

(a) RESIDENCE No. 132 N. Ellwood av ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Connelly.

DATE OF BIRTH (month, day, and year) June 9, 1860

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	4		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Labor

(b) General nature of industry, business, or establishment in which employed (or employer) O+O

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Patrick Connelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Caulfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

PARENTS

14 Informant (Address) Joseph Connelly. 132 N. Ellwood av

15 Filed , 19 ADH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 19, 1927, that I last saw h alive on Oct 20, 1927

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) ~~Gradual~~ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tilson, M. D.

10/22, 1927 (Address) 815 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Oct. 24, 1927

20 UNDERTAKER John J. Moran

ADDRESS 3000 E Baltimore St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26713 ✓

E 26713

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 N. Potomac ST. 6-11 WARD)

2-FULL NAME Daniel Goetz

(a) RESIDENCE NO. 31 N. Potomac St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Goetz

6 DATE OF BIRTH (month, day, and year) May 9, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant (Address) Elizabeth Goetz 31 N. Potomac St.

15 Filed ..19.. Registrar

C. HAMPSON JONES, M. D.

OCT 23 1927

RKA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 27

17 I HEREBY CERTIFY, That I attended deceased from May 1 19 27 to Oct 20 19 27.

that I last saw him alive on Oct 20 19 27

and that death occurred, on the date stated above, at 4-0 m.

The CAUSE OF DEATH* was as follows: Interstitial Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Dropsy.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hunt Hawkins, M. D.

Oct 24 '27 (Address) 2738 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery.

DATE OF BURIAL Oct 24 1927

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26714

CERTIFICATE OF DEATH.

188-003 E 26714

1-PLACE OF DEATH Enroute

City of BALTIMORE: (No. St. Joseph Hospital St., 12-14 Ward)

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Bernard Sweeney

(a) RESIDENCE NO. 418 E. 20th St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1921

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	6	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John P. Sweeney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Theresa A. Wirth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Mother
(Address)

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Oct 21/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Intraabdominal Hemorrhage
Accidently run over by Autotruck
Greenmount Ave & 22nd St

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Kalas M. D.
(Coroner)

10-20, 27 (Address 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Interbathedralbom	10/24 1927

20 UNDERTAKER J. J. Moran ADDRESS 3060 E Balto St.

Spec. -7-17-26—A Co.—200 Bks.

E 26715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26715

REGISTERED NO. 13-52 X 101-04

1-PLACE OF DEATH

City of BALTIMORE: (No. 4129-Roland-Av. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ozella Lacretia Jollie

(a) RESIDENCE NO. 4129-Roland-Av. St. Ward Deland, Florida.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 15 ds. How long in U. S. if of foreign birth? 69 yrs. 5 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Redmond T. Jollie

6 DATE OF BIRTH (month, day, and year): May-8-1858

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	69	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town): Conway,

(State or country): S.C.

PARENTS

10 NAME OF FATHER: Asa C. Causey

11 BIRTHPLACE OF FATHER (City or town): Conway

(State or country): S.C.

12 MAIDEN NAME OF MOTHER: Fannie Martin

13 BIRTHPLACE OF MOTHER (city or town): Conway

(State or country): S.C.

14 Informant: Mr. Chas. H. White Jr. (son)

(Address): 4129-Roland Av., City.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1927, to Oct. 22, 1927, that I last saw h[illegible] alive on Oct. 22, 1927, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy with Probably Pneumonia but no Physical Signs.

(duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 12 Hours.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By Physical Signs

(Signed) M. J. Porter, M. D.

10/23. 1927 (Address) 422 Roland Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wash. D.C, ~~Georgia~~.

Date of Burial: Oct/23/1927

20 UNDERTAKER: [illegible] EN COMPANY (WILLIAM F. HOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

OCT 23 1927

Spec.—7-17-26—A Co.—200 Bks.

E 26716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

23 E 26716

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE; (No. Mercy Hospital St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peninah Hoss

(a) RESIDENCE NO. 3130 Abellane St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 38 yrs. 11 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ralph J. Hoff

6 DATE OF BIRTH (month, day, and year): Nov-1-1888

7 AGE — Years: 38 Months: 11 Days: 20 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H.W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Reading Pa

(State or country)

PARENTS

10 NAME OF FATHER Edmond Sharman

11 BIRTHPLACE OF FATHER (City or town) Reading Pa.

(State or country)

12 MAIDEN NAME OF MOTHER Ida Derr

13 BIRTHPLACE OF MOTHER (city or town) Chester

(State or country) Pa

14 Informant Mr. Ralph J. Hoff

(Address) 3130 Abellane

15 Filed ..... 19 ..... Registrar

RPH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21/27 19

17 I HEREBY CERTIFY, That I attended deceased from 10/15/27 19 to 10/21/27 19

that I last saw her alive on 10/21/27 19

and that death occurred, on the date stated above, at 10 P.M. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. about 7 mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) J. S. Whitacre M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Reading Pa. Date of Burial Aug 23 1927

20 UNDERTAKER [illegible] COMPANY (Successor) ADDRESS 108 W. NORTH AVE

Cor.—1-12-23—M&T—100 Bks.

E 26717

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26717

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210-Goodwood Gardens St., 12-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Jackson Lindsay

(a) RESIDENCE NO. 210 Goodwood Gardens ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 0 mos. 16 ds. How long in U. S., if of foreign birth? 64 yrs. 0 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Anne B. Lindsay

6 DATE OF BIRTH (month, day, and year) Oct-5-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	0	16	

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer) C. W. Lindsay-Sons
(c) Name of employer self

8 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Geo. W. Lindsay

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Auld

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Mr. Geo. Carey Lindsay (brother)
(Address) Cittings-York Road, City.

Filed , 192 Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) , M. D.
(Coroner.)

10/23/27 (Address) 1872 Roland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	October/24/27 192

20 UNDERTAKER STEVENS & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.–7-17-26—A Co.—200 Bks.

E 26718

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

155 E 26718

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Staines

(a) RESIDENCE NO. 1025 Wolf St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1924.

7 AGE: Years 6 Months — Days —

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Frank J Staines

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Elenore Moore

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Frank J Staines

(Address) 1025 Wolf

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 21 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19 1927, to Oct 21 1927, that I last saw h[illegible] alive on Oct 21 1927, and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Surgical Shock following operation

(duration) ... yrs. 2 mos Days da.

CONTRIBUTORY (Secondary) Osteomyelitis of Right Femur.

(duration) ... yrs. Two mos Two da.

18 Where was disease contracted

If not at place of death? Md. State Sanitorium

Did an operation precede death? Yes Date of Oct 21 - 1927

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) C B Claudson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dallo Cemetery

Date of Burial 10/24 192

20 UNDERTAKER Edward Toulson

ADDRESS Wade 2259 E Blvd

Spec.—1-12-23—M&T—500 Blks.

E 26719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 26719

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 721 E. 22nd. ST., 9-46 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie R. Wright

(a) RESIDENCE NO. 721 E. 22nd. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas S. Wright

7 DATE OF BIRTH (month, day, and year) Jan. 27. 1849

8 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	8	24	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER John Plummer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Frances Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Mrs. Helen L. Tuttle
(Address) 721 E. 22nd. St.

Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21/1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1927, to Oct 21, 1927, that I last saw h[illegible] alive on Oct 21, 1927, and that death occurred, on the date stated above, at 5-15 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary) Bronchial Pneumonia (duration) ..... yrs. ..... mos. 2 ds.

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No Symptoms

What test confirmed diagnosis?

(Signed) Thomas J. Wade M. D.

19 (Address) 532 E. 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 10/24 19 27

20 UNDERTAKER Henry M. Myers Sons

ADDRESS [illegible]

Cor.—12-9-25—A Co.—200 Bks.

E 26720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 E 26720

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3508 Powhatan Avenue St. 15-61 Ward)

2-FULL NAME Catherine Jones Gould

(a) RESIDENCE NO. 3508 Powhatan Avenue St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. -- mos. -- ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Ross Gould

6 DATE OF BIRTH (month, day, and year) -------

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or...min.
	49	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Rieman Jones

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Keenan

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant Katherine K. Gould

(Address) 3508 Powhatan Avenue

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry and Her (Autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Broken Compression

(Duration) ... yrs. ... mos. 1 ds.

Oct 23/27 G C Hades M. D.

(Coroner)

, 19 (Address) 143 W Pray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — Date of Burial 10/24 1927

20 UNDERTAKER Henry A. Mears & Son — ADDRESS 805 N. Calvert

Cor—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26721
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

113 E 26721
REGISTERED NO.

City of BALTIMORE: (No. 2124 Wilhelm St. W-19 Ward)

2-FULL NAME Virginia M. Webb

(a) RESIDENCE NO. 2124 Wilhelm St. Ward
(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: White | 5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 19 1927

7 AGE: Years — | Months 9 | Days 4 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Milton A. Webb

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER: Cecelia Craumer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md.

14 Informant (Address): Milton A. Webb 2124 Wilhelm St.

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
filed that said deceased came to
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions 3 hours
CONTRIBUTORY (Secondary) Intestinal Indigestion
(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Address) Curtis Bay, Md.
Oct 23 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs.. mos.., ds. In the State yrs.. mos.. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden Date of Burial: Oct 24 1927

20 UNDERTAKER: Churchwell & Son ADDRESS: 361 Chestnut

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26722 160 E 26722

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 327 S. Parrish St. 19-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey Mildred Earley

(a) RESIDENCE NO. 327 S. Parrish St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. de.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): September 16, 1927

7 AGE — Years: — Months: 1 Days: 17

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER: Samuel Earley

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER: Lillian Thater

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant: Mildred Thater

(Address) 1404 Ramsay St.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 23 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22nd, 19 27, to Oct. 23, 19 27.

that I last saw her alive on Oct 22nd, 19 27,

and that death occurred, on the date stated above, at 8 — A. m.

The CAUSE OF DEATH* was as follows:

Meningitis

Probably

(duration) yrs. 1 mos. 30 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) C. L. Nuckols, M. D.

, 19 (Address) 130 S. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: Oct 26 1927

20 UNDERTAKER: Harry H. Woltz & Co — ADDRESS 1534 W. Lombard St.

Important: See instructions on back of certificate.

E 26723 C[illegible] & S. A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 ✓ E 26723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 128 Welcome Alley. 42-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Joynes.(C)

(a) RESIDENCE NO. 128 Welcome Alley. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Divorced.

5a If ~~married, widowed or divorced~~ HUSBAND of ~~WIFE of~~ Blanche Joynes.(C)

6 DATE OF BIRTH (month, day, and year) February 16, 1885.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Joynes.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Sarah Croxton.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Philip Joynes.(C) brother.

(Address) 1019 Olive St.

15 Filed , 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

10/21 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

20 UNDERTAKER — ADDRESS

C. H. Hamson

Spec.--12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 26724

1-PLACE OF DEATH

REGISTERED NO. E 26724

City of BALTIMORE: (No. Sinai Hospital St. Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Sylvan Schenthal.

(a) RESIDENCE NO. 2321 Eutaw Place St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23 1877

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	49	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Shoes

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster, Md

(State or country)

PARENTS

10 NAME OF FATHER Harry Schenthal

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Lydia Halle

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Mrs. L. Schenthal

(Address) 2321 Eutaw Place

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1927 19

17

I HEREBY CERTIFY, That I attended deceased from Oct 11 1927, to Oct 23, 1927, that I last saw h.. alive on Oct 23, 1927, and that death occurred, on the date stated above, at 2:10 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Murray Shenthal, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Date of Burial

Balto. Hebrew Cem. 10/24/1927

20 UNDERTAKER ADDRESS

Abid Sondheim 118 20th W. Md.
Royal Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26725

CERTIFICATE OF DEATH.

90 E 26725

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3618 Elm Ave St. 13-52 Ward)

2-FULL NAME John L Calk

(a) RESIDENCE NO. 3618 Elm Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Calk

6 DATE OF BIRTH (month, day, and year) Aug 3-1846

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	81	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Co.

PARENTS

10 NAME OF FATHER Henry Calk

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. Frank Calk

(Address) 3618 Elm Ave

15 Filed....., 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquest.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquest.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

Oct 23. 1927 (Address) 3692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Marys Lauxdale Oct 26 1927

Date of Burial

20 UNDERTAKER Alf S Marshall ADDRESS 3537 Fallsrd

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26726

E 26726

160 W Washington

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 Mayfield Ave ST., 21-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred I. Harman

(a) RESIDENCE NO. 32 Mayfield Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 16-1927

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Reuben Harman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City

12 MAIDEN NAME OF MOTHER: Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: Reuben Harman

(Address) 32 Mayfield Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 22, 1927, to Oct 24, 1927, that I last saw her alive on Oct 23, 1927, and that death occurred, on the date stated above at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

inability to assimilate food

(duration) yrs. mos 27 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

Oct 24 1927 (Address) 846 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Ridge — DATE OF BURIAL: Oct 24 1927

20 UNDERTAKER: A S Marshall — ADDRESS: 353 Fulton

OCT 24 1927 HAMILTON JONES M

Spec.—1-12-28—M&T—500 Blks.

E 26727 ~~E 26737~~ HEALTH DEPARTMENT—CITY OF BALTIMORE E 26727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST. 1-2 WARD)

REGISTERED NO. 88

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schneberger

(a) RESIDENCE NO. 642 South Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced. (write the word): Married

6 If married, widowed, or divorced (a) ~~HUSBAND~~ or (a) WIFE of Michael Schneberger

DATE OF BIRTH (month, day, and year) 2-5-85

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	10	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home mfr.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Tagloff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) JOHNS HOPKINS HOSPITAL

Filed OCT 24 1927 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct-7 1927, to Oct 21 1927, that I last saw h[illegible] alive on Oct-21 1927, and that death occurred, on the date stated above, at 1:15 P m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis 8 (History)

(duration) yrs. mos ds

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. 4 mos? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? laboratory + autopsy

(Signed) W Lindsay Watkins, M. D.

10/31/1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Oct 25 1927

20 UNDERTAKER: George W. Zirkler — ADDRESS: 1737 E. Eager st

Spec.—1-12-23—M&T—500 Blks.

E-26728 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26728

CERTIFICATE OF DEATH.

11-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Fulton Ave., ST. 27-49 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C. Hession

(a) RESIDENCE NO. #7 Cold Spring Ave., ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 1st. 1927

7 AGE — Years: — Months: 2 — Days: 21 — If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William J. Hession

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Haydn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22nd, 1927

17 I HEREBY CERTIFY, That I attended deceased from October 17, 1927 to October 22, 1927, that I last saw him alive on October 22, 1927 and that death occurred, on the date stated above, at 7:30 A m

The CAUSE OF DEATH* was as follows:

Influenza 5 Days

Otitis Media

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw Oleemaker, M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: 10/24/27

20 UNDERTAKER: Geo A. Kirby Sons & Stryde ADDRESS

Spec.—1-12-23—M&T—500 Bks.

E 26729 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26729

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE, (No. 7-9 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert UPHOFF

(a) RESIDENCE NO. S Sparrows Point ST. WARD
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word): Child

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-9-22

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	5	4	13	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Fred - UPHOFF

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland -

12 MAIDEN NAME OF MOTHER Catherine Kirschenhofer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address)

15 Filed ..19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1927, to Oct. 22, 1927, that I last saw h[illegible] alive on Oct 22, 1927, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic carditis c
myocardial failure

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) S. G. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct 24 1927

20 UNDERTAKER: Jas E. Miller & Son — ADDRESS: 2334 Jeffer[illegible]

JOHNS HOPKINS HOSPITAL OCT 24 1927 C. HAMPSON JONES

Spec.—7-17-26—A Co.—200 Bks.

E 26730 Scoggins E 26730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 90

City of BALTIMORE: (No. 17-25 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Scoggins

(a) RESIDENCE NO. 1313 Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Md

PARENTS

10 NAME OF FATHER Robt Scoggins

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Md

14 Informant .....

(Address) Hosp. Records

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/15, 1927, to 10/31, 1927, that I last saw h[er] alive on 10/31, 1927, and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

Chronic Myocarditis 1 year

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of .....

Was there an autopsy? —

What test confirmed diagnosis? Clinical Findings

(Signed) [illegible], M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Auburn Cemetery	Oct 25, 1927
20 UNDERTAKER	ADDRESS
Wm. Kate R. Williams	N. Edmondson

Very important. See instructions on back of certificate.

HARRISON JONES, M.

Spec.-7-17-26-A Co.-200 Bks.

E 26730 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26731

CERTIFICATE OF DEATH

101-001

1-PLACE OF DEATH REGISTERED NO.

City of BALTIMORE: (No. Provident Hospital St. 17-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine Johnson

(a) RESIDENCE NO. 772 W. Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widnwed, or divorced HUSBAND of (or) WIFE of: Eugene Johnson

6 DATE OF BIRTH (month, day, and year): March 8, 1899

7 AGE: Years 28 Months 7 Days 13 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Franklin

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Mary Watkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mary Giles

(Address) Hilltop Md

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 19 27

17 I HEREBY CERTIFY, That I attended deceased from 10/17, 1927, to 10/21, 1927, that I last saw her alive on 10/20, 1927, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonic

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Signs

(Signed) John A. Lanzer M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — Date of Burial: Oct. 24, 1927

20 UNDERTAKER: Mrs. Katie C. Williams — ADDRESS 322 N. Schroeder St

Spec.—1-12-23—M&T—500 Blks.

E 26732

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26732

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 4-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Krumrein (KRUMREIN)

(a) RESIDENCE NO. 722 N. Kenwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, ~~HUSBAND~~ of or) WIFE of late John L. Krumrein

6 DATE OF BIRTH (month, day, and year) Sept 18/65

7 AGE: Years 62 Months 1 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Gosler - John.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary E. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1927

17 I HEREBY CERTIFY, That I attended deceased from July 4 , 1927 , to Oct 21 , 1927 , that I last saw h[illegible] alive on Oct 21 , 1927 , and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, uterus

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Uremia, amputation

(duration) — yrs. 1 1/2 mos. — ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of July 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Robert T. Frank. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London PK — DATE OF BURIAL 10/24 1927

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Orleans

AUG 2 A 1927 C. HAMPSON JONES, [illegible]

Spec. 1-17-26 A Co. 200 Bks.

E 26733

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26733

CERTIFICATE OF DEATH

129

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 813 N. Montford Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Mehling

(a) RESIDENCE NO. 813 N. Montford Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Margaret Mehling

6 DATE OF BIRTH (month, day, and year) Dec. 6/62

7 AGE — Years: 64 Months: 10 Days: 16 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Md. Title Guar. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Ft. Bato

(State or country)

PARENTS

10 NAME OF FATHER Haby Mehling

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Mullator

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) France

14 Informant Margaret Mehling

(Address) 813 N. Montford

15 Filed OCT 24 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22/27

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1926, to Oct. 22, 1927, that I last saw him alive on Oct. 22, 1927, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden, M. D.

10/24/1927. (Address) 1216 N. Caroline St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. — Date of Burial: 10/25 19 27

20 UNDERTAKER: Phil. Herring — ADDRESS: 2016 Orleans St

Spec.—1-12-23—M&T—500 Blks.

E 26734 E 26734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+117

1-PLACE OF DEATH Church Home - Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. Broadway St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Poff.

(a) RESIDENCE NO. Delta Penn ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 12				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER Henry Poff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Callie Auble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mr. Henry Poff

(Address) Delta Pa

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1927, to Oct 24, 1927, that I last saw h[illegible] alive on Oct 24, 1927 and that death occurred, on the date stated above, at 12:40 m.

The CAUSE OF DEATH* was as follows:

Appendicitis. Acute

(duration) yrs. mos. 3 (days)

CONTRIBUTORY (Secondary) Peritonitis Intestinal Obstruction

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Delta Penn

Did an operation precede death? Yes Date of Oct 22 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical Operation

(Signed) George B Buel, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta Pa — DATE OF BURIAL Oct 24 1927

20 UNDERTAKER Wm Parker Sons — ADDRESS North St Pa

Spec.—1-12-23—M&T—500 Bks.

E 26735

E 26735

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5520 (St.) Gwynn Oak Ave (Ward) 24

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Mae Blagett

(a) RESIDENCE NO. 5520 Gwynn Oak Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) Married.

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of T. Darby Blagett.

6 DATE OF BIRTH (month, day, and year) April 19th 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Tracy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Mary E Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rockville Md.

14 Informant T. Darby Blagett
(Address) 5520 Gwynn Oak Ave

15 Filed ..... 19 .... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from about 5 yrs. ago, to Oct 22, 1927.

that I last saw ~~him~~ alive on Oct 22 1927.

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Heart disease (mitral insufficiency).

(duration) 5 or 6 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical sign & symptoms

(Signed) H. T. Stansbury M. D.

Oct 23, 1927 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Oct 25th 27

UNDERTAKER Hamel Bittrand & Fore — ADDRESS 1723 W Lafayette Ave

OCT 24 1927 CLERK PERSON JONES, M.D.

Spec.—1-12-23—M&T—500 Bks.

20756 E 26736

HEALTH DEPARTMENT—CITY OF BALTIMORE E 26736

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSP. ST. 16-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Johnson Moore

(a) RESIDENCE NO. 924 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

6a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Wife

6 DATE OF BIRTH (month, day, and year) 1880

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47				

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Own work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) South Carolina

10 NAME OF FATHER Sterling Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Fanny Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

PARENTS

14 Informant Negro (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... JAN 24 19...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15 , 1927 , to Oct. 22 , 1927.

that I last saw her alive on Oct. 22 , 1927

and that death occurred, on the date stated above, at 3:50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos 3 ds. Dated

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 18.

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Robert T. Isaac M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Oct 24 1927

20 UNDERTAKER Thomas E. Kelson.

ADDRESS 1303 Pressman

Cor.—12-9-25—A Co.—200 Bks.

E 26737

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26737

CERTIFICATE OF DEATH.

REGISTERED NO. 84

1-PLACE OF DEATH

City of BALTIMORE: (No. 2162-15th St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T Charles (CHARLES)

(a) RESIDENCE NO. 216-15th St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26th 1922

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	5	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER John T. Charles

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER agnes Pratt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md

14 Informant agnes Smith

(Address) 216 S Fifteenth St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Injury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Drowning

Duration: yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Idiotic

Duration: yrs. mos. 27 ds.

Signed) Oct 27/27 J C Charles M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery Date of Burial: Oct. 29 1927

20 UNDERTAKER: Lilly & Feiler ADDRESS: 405 S. Wolfe St

Cor.—1-12-23—M&T—100 Blks.

E 26738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 E 26738

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Parkwood ~~Ave~~ St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter E Roderick

(a) RESIDENCE NO 606 Parkwood Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Eleanore H. Roderick

6 DATE OF BIRTH (month, day, and year) Oct 29, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	11	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Copy Reader
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Sun Papers

9 BIRTHPLACE (city or town) (State or country) Washington D C 10-22

PARENTS

10 NAME OF FATHER Edmund A Roderick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Charlotte Merkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Wife
(Address)

15 Filed , 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ill. Gas asphyxiation

(Suicide)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H H Collier, M. D.

(Coroner) , 192 7 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakington Va.	Oct 25 192

20 UNDERTAKER Henry J Jenkins Sons ADDRESS

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26739

E 26739

CERTIFICATE OF DEATH.

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 33 Warner St. ST., 25-17 WARD)

2-FULL NAME Annie Coap, 33 Warner St.

(a) RESIDENCE NO. 33 Warner St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Coap

6 DATE OF BIRTH (month, day, and year): April 3-1875

7 AGE: Years 52 Months 6 Days 17 If LESS than 1 day, ... hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housedutes

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joseph Queen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Geo. Coap (Address): 33 Warner St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/21/1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1927 to Oct 21, 1927 that I last saw h alive on Oct 21, 1927 and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Septic Infection

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herbert A Davis, M. D.

, 19 (Address) 1227 Mosher Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn DATE OF BURIAL: Oct 24 1927

20 UNDERTAKER: Frank D Stanley ADDRESS: 3[illegible]

C. HAMPSON JONES, M.

24 1927

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26740 PLACE OF DEATH

REGISTERED NO. E 26740

CITY OF BALTIMORE (No. 1815 New Pittsburg Ave St.) 26-27 (WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Clearence L. Spencer

(Residence in Baltimore: No. 1815 New Pittsburg Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: May (Month) 27 (Day) 1926 (Year)

7 AGE: 1 yrs. 4 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Edward L. Spencer

11 BIRTHPLACE OF FATHER (State or country): Carroll Co. Md

12 MAIDEN NAME OF MOTHER: Fredericka L. Schuh

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward L. Spencer.
(Address) 1815 New Pittsburg

15 Filed ... 191 ... HAMILTON JONES, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 23 (Day), 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19, 1927, to Oct 23 1927, that I saw him alive on Oct 23, 1927, and that death occurred, on the date stated above, at 2:45 p.m.
The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. 10 ds.

Contributory (SECONDARY) Broncho-Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) A. W. Reier M. D.
Oct 24. 1927 (Address) Dundalk, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Carmel Cem. DATE OF BURIAL: Oct 25 1927

20 UNDERTAKER: John Burns Sons ADDRESS: Towson

Spec.—1-12-23—M&T—500 Blks.

E 26741

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26741

CERTIFICATE OF DEATH.

23

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Sinclair Lane ST.) (6-16 WARD)

2-FULL NAME William J. Mann.

(a) RESIDENCE No. 2013 Sinclair Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 18/1908.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	18	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew Mann.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Fritz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14

Informant Andrew Mann

(Address) 2013 Sinclair Lane

15

Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1927, to Oct-22, 1927, that I last saw h— alive on Oct 22, 1927, and that death occurred, on the date stated above, at 4 a — m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Coma —

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

. 19 (Address) 125 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery

DATE OF BURIAL: Oct 25 1927

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Harford

Spec.—12-9-25—A Co.—200 Bks.

E 26742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 E 26742

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital 27-S Ward)

2-FULL NAME Harold Rosenthal

(a) RESIDENCE NO. 93 Rogers Ave St Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 4 mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 3 yrs. 4 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	3	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Jacob Rosenthal

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Helen Benson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Jacob Rosenthal

(Address) 93 Rogers Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23-27 19

I HEREBY CERTIFY, That I attended deceased from 10-16 1927, to 10-23, 1927,

that I last saw h Living alive on 10-23, 1927

and that death occurred, on the date stated above, at 7 15 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Harry Weinthal, M. D.

10/24/1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run Date of Burial 10-24 1927

20 UNDERTAKER Sol Levinson & Bro ADDRESS 111 E Balto St

Spec.—1-12-23—M&T—500 Bks.

E 26743 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26743

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hosp. St., 7713 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Morgan

(a) RESIDENCE NO. 1028 Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced, (write the word): Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 10, 1900

7 AGE: Years 27 | Months 5 | Days 12 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Marine

(c) Name of employer Barge "Mohawk"

9 BIRTHPLACE (city or town) (State or country) Okla

PARENTS

10 NAME OF FATHER James Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indian Okla

12 MAIDEN NAME OF MOTHER Helen Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Arkansas

14 Informant Clinical Record (Address) 615 Marine Hosp.

15 Filed OCT 24 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 16, 1927, to Oct 22, 1927, that I last saw him alive on Oct 22, 1927, and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, Chronic

(duration) undetermined

CONTRIBUTORY (Secondary) Tuberculosis Laryngitis

(duration) about 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory, X Ray

(Signed) Ralph Hartman M. D.

(Address) 615 Marine Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys (Hampden) DATE OF BURIAL: Oct 25 1927

20 UNDERTAKER: E. LeRoy Stiffler ADDRESS: 125 North Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26744

38 E 26744

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS [redacted] St. 11-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Boyle

(a) RESIDENCE NO. 866 W. Hamburg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Mass.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant [redacted] BALTIMORE CITY HOS

(Address) [redacted]

15 Filed ....., 19 ..... Registrar

1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1925, to Oct. 21, 1927, that I last saw him alive on Oct 21, 1927 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

C. N. S. Amyloidosis

Edema of Lungs

Hypostatic Pneumonia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Bronchopneumonia

(Secondary)

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross & Sect

(Signed) C. Sheldon Boyle, M. D.

, 19 (Address) CITY HOS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

C. HAMPSON JONES, M. D. Commissioner of Health

Very important. See instructions on back of certificate.

HALTIMORE CITY HOSPITALS
OCT 2 1928
UNIVERSITY OF MARYLAND

Spec.—1-10-21—M&T—1500 Bks.

26745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26745

118-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 S. Bouldin St., 26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Spencer

(a) RESIDENCE NO. 211 S. Bouldin ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: the late David Spencer

6 DATE OF BIRTH (month, day, and year): Nov. 27th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs John W. Eomen

(Address) 3224 Hart ave.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 22nd 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1927, to Oct. 22, 1927, that I last saw her alive on Oct. 22, 1927, and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert. L. Kirk, M. D.

10/27, 1927 (Address) 3126 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Oct 25th 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26746

CERTIFICATE OF DEATH

90 12 E. 26746

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1911 E. Pratt St., 2-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Noah

(a) RESIDENCE NO. 1911 E. Pratt St. 2 Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Noah.

6 DATE OF BIRTH (month, day, and year) March 12th 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	73	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Georg Noah.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Agnes Noah.

(Address) 1911 E. Pratt St.

15 Filed ....., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 Oct. 23rd

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 26, to Oct 23, 19 27; that I last saw h[im] alive on Oct. 19, 19 27; and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH was as follows:

Hypertension, Vascular Heart and Paralysis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Chas L. Wilkins, M. D.

Oct 24 1927 (Address) 2248 E 39

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial: Oct. 26 1927

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 1032 Hugh St

Spec.—1-12-23—M&T—500 Blks.

E 26747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 26747

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327 Webster ST. 24-33 WARD)

2-FULL NAME James. Slemaker.

(a) RESIDENCE NO. 1327 Webster ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R. Slemaker.

6 DATE OF BIRTH (month, day, and year) 7-27-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Advent Chapel.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md.

PARENTS

10 NAME OF FATHER John H. Slemakes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Slemakes (Address) 1327 Webster

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 16, 1927, to Oct 22, 1927, that I last saw h[illegible] alive on 10/22, 1927, and that death occurred, on the date stated above, at 1230 Pm

The CAUSE OF DEATH* was as follows:

Myocarditis (duration) yrs. mos. 24 hrs.

CONTRIBUTORY (Secondary) Chron Valv Heart dis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L J Durlington, M. D.

10/22/1927 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leader Hill Cem.	10/25 1927
20 UNDERTAKER	ADDRESS
J. Fen McCully	130 E Fort

1927 HAMPSON JONES M. D.

Spec. 7-17-26—A Co.—200 Bks.

E 26748

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26748

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No.) Mercy Hospital (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Schiener

(a) RESIDENCE NO. 2834 W. North Ave (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed ~~divorced~~ (or) WIFE of: Wm D Schiener

6 DATE OF BIRTH (month, day, and year): 10/10/1890

7 AGE — Years: 37 — Months: — Days: 19 — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Wm Schiffman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Catherine Jenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Wm D Schiener 2834 W North Ave

15 Filed . 19 Registrar

OCT 27 1927 C. THOMPSON JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 10-23-27

17 I HEREBY CERTIFY, That I attended deceased from 10-3-27, 19 , to 10-23-27, 19 ,

that I last saw h[illegible] alive on 10-23-27, 19 ,

and that death occurred, on the date stated above, at 1 30 ~~pm~~ am in.

The CAUSE OF DEATH* was as follows:

Carcinoma breast right with metastasis to brain and lungs

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Metastasis to brain with cardiac failure

(duration) yrs. mos. Weeks

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of nov 9 '26

Was there an autopsy? No

What test confirmed diagnosis? Surgical findings

(Signed) [illegible] M. D.

. 19 (Address) Mary Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem Co — Date of Burial: 10/26/1927

20 UNDERTAKER: J F Staley & Sons — ADDRESS: 1318 Eutaw St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26749 E 26749

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1577 Eutaw St. (Ward) 23

2-FULL NAME Mary E. Rudolph

(a) RESIDENCE NO. 1577 E. Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W.

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John A. Rudolph

6 DATE OF BIRTH (month, day, and year) — — 1865

7 AGE: Years 62 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Jack McAllister

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Mary O'Neill

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Mary Rudolph

(Address) 1577 E. Eutaw St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Oct. 22 —

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1927, to Oct 21, 1927,

that I last saw h.. alive on Oct. 21, 1927,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Progressive muscular atrophy

(Central)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY Senile

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Evidence

(Signed) John S. Rienhoff, M. D.

, 1927 (Address) 102 W. 22nd Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Cathedral Cem 10/25 1927

20 UNDERTAKER ADDRESS

J. J. Gahegan Inc 1218 Eight St

Spec.–7-17-26—A Co.—200 Bks.

SMITH ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26750

CERTIFICATE OF DEATH

74-001 E 26750

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2455 Maryland Ave St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances R. Smith

(a) RESIDENCE NO. 2455 Maryland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James R. Smith

6 DATE OF BIRTH (month, day, and year): Sept 6 1855

7 AGE: Years 72 Months 1 Days 12 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. City

(State or country)

PARENTS

10 NAME OF FATHER James F. Tilton

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER Araminta

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: E. Royal Smith

(Address) 2455 Maryland Ave.

15 Filed 1927 by C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 23 19 27

17 I HEREBY CERTIFY, That I attended deceased from August 18, 1927, to October 23, 1927, that I last saw h[illegible] alive on October 22, 1927, and that death occurred, on the date stated above, at 9.48 A. m.

The CAUSE OF DEATH* was as follows: Cerebro vascular hypertension

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. 2 mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Thos. M. O'Rourke M. D.

10/29/27 (Address) 2435 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. Date of Burial 19

20 UNDERTAKER: John C. Mitchell & Sons ADDRESS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20748 26751

CERTIFICATE OF DEATH.

x 49 E 26751

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. [illegible] St. 7-9 WARD)

2-FULL NAME George H. Kenly Jr

(a) RESIDENCE No. 602 Manhattan St. Burlington Colo WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~: Child

5a If married, widowed, or divorced HUSBAND of or) WIFE of: single

6 DATE OF BIRTH (month, day, and year) 11-11-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	5 yrs	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Georgia

PARENTS

10 NAME OF FATHER: George H. Kenly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Veronica Coppes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga

14 Informant: Mother JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..., 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1927, to Oct. 24, 1927, that I last saw him alive on Oct. 24, 1927, and that death occurred, on the date stated above, at 4 20 a m.

The CAUSE OF DEATH* was as follows:

Brain tumor, cerebellar,

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Post operative Infection

(duration) yrs. 0 mos. 7 ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? Yes Date of Oct 14/27

Was there an autopsy? No

What test confirmed diagnosis? Cultures

(Signed) Lyman Means, M. D.

10/24 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: Oct 25 1927

20 UNDERTAKER: John C. Whitehill & Son ADDRESS: 1900 Eutaw

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26752

CERTIFICATE OF DEATH.

1129

E 26752

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5429 Vanner Ave 27-55 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Dexter L. Hanbros

(a) RESIDENCE NO. 5429 Vanner Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced. HUSBAND of (or WIFE of): Marie R. Hanbros

6 DATE OF BIRTH (month, day, and year): May 4/1882

7 AGE — Years: 45 — Months: 5 — Days: 13 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchmaker

(b) General nature of industry, business, or establishment in which employed (or employer): Retail

(c) Name of employer: D. Rist Manor

9 BIRTHPLACE (city or town): New Haven

(State or country): Conn.

PARENTS

10 NAME OF FATHER: Louis Hanbros

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Denmark

12 MAIDEN NAME OF MOTHER: Anna Elsedeund

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Denmark

14 Informant: Mrs Marie R Hanbros

(Address) 5429 Vanner ave.

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 22/27 19

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3 1927, to Oct 22 1927, that I last saw him alive on Oct 22nd 1927, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows: Intestinal Hepatic

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Hypertension & Purpura Hemorrhagica

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) Eric Smith, M. D.

(Address) 1605 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: Oct 26 1927

20 UNDERTAKER: Numan Co — ADDRESS: 501 E North Ave

C. THOMPSON JONES, M.D.
1927

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26753 ✓ E 26753

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4701 Homer Ave ST. 27-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes L Christie

(a) RESIDENCE NO. 4701 Homer Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ Wife of Harry O Christie

6 DATE OF BIRTH (month, day, and year) Jan 14 1866

7 AGE	Years	Months 9	Days 9	If LESS than 1 day, hrs. or min.
61				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer none

PARENTS

9 BIRTHPLACE (city or town) (State or country) New Jersey

10 NAME OF FATHER Robt St Clair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Otis H Christie (Address) 4701 Homer Ave

15 Filed ... A. 1927 ..., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1927, to Oct 23, 1927, that I last saw her alive on Oct 23, 1927, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos Two ds.

CONTRIBUTORY (Secondary) Diabetes & Chronic Myocarditis Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical Evidence

(Signed) C. H. Jones, M. D.

10-23 1927 (Address) 5106 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct 26 1927

20 UNDERTAKER W M Cook

ADDRESS 502 E North

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26754

CERTIFICATE OF DEATH.

60-002

E 26754

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1429 Mt. Royal Avenue (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella V. Buckley

(a) RESIDENCE NO. 1429 Mt. Royal Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Buckley

6 DATE OF BIRTH (month, day, and year) --------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk
(State or country) Virginia

PARENTS

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) "

14 Informant E. Alfred Buckley
(Address) 2233 Guilford Avenue

15 Filed ... , 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/23 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1927 to Oct 22, 1927

that I last saw her alive on Oct 22, 1927

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Toxic adenoma (Thyroid)

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough M. D.

, 19 (Address) 2923 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 10/25 1927

20 UNDERTAKER Henry B. Mears & Son

ADDRESS 805 N. Calvert

C. HAMPSON JONES, M.D.
1927

Spec.—1-12-23—M&T—500 Bks.

E 26755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

95-001 E 26755

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Eutaw Place ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Wardenburg

(a) RESIDENCE NO. 1700 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: William F. Wardenburg

6 DATE OF BIRTH (month, day, and year): July 11, 1843

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
84	2 3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Lynch

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Stewart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant (Address) Nathaniel D. Sollers 1914 Mt. Royal Terrace

15 Filed , 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1927

17 I HEREBY CERTIFY, That I attended deceased from January, 1921 to Oct. 23rd, 1927, that I last saw her alive on Oct. 23rd, 1927, and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia, Left side
involving Diaphragm & rectum
& Left Adder

(duration) 6 yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Congestion of Lungs. (Hypostatic) (duration) about 1 yrs. mos. ds.

18 When was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? X

(Signed) Eduard C. Price, M. D.

10-24-27 (Address) 1705 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 10/25 19 27

20 UNDERTAKER: Henry H. Mears & Son

ADDRESS: 805 N. Calvert

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26756

CERTIFICATE OF DEATH.

E 26756

REGISTERED NO. 101-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belvedere Hotel ST. 11-15 WARD)

2-FULL NAME Mary Veader Leonard

(a) RESIDENCE NO. Belvedere Hotel ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Sheldon Leonard

6 DATE OF BIRTH (month, day, and year) June 2, 1866

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
61	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Maryland

PARENTS

10 NAME OF FATHER Daniel H. Veader

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Haven Conn.

12 MAIDEN NAME OF MOTHER Mary Camden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Maryland

14 Informant (Address) Dr. Veader Leonard Roland Park Apartments

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1927, to Oct 22nd, 1927.

that I last saw h alive on Oct 22nd, 1927.

and that death occurred, on the date stated above, at 11 00 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Jefferson Buck M. D.

10/23 1927 (Address) 140 S. Club Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Haven, Connecticut	10/25 1927

20 UNDERTAKER Henry W. Weaver and Louis M. Kalvert ADDRESS

via Penn. Railroad Escort - Dr. Veader Leonard

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26757

CERTIFICATE OF DEATH.

74-001 V

E 26757

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No 233 N. Gilmor St. 19-27 Ward)

2-FULL NAME John A. Shook

(a) RESIDENCE NO. 233 N. Gilmor St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 22nd 1855

7 AGE: Years 72 Months 2 Days 1 If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Albert A. Shook

11 BIRTHPLACE OF FATHER (city or town): [illegible]

(State or country)

12 MAIDEN NAME OF MOTHER: Susan Lebond

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Mrs. Shook (Address) 233 N. Gilmor St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 25th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Tho. B. Horton M. D.

(Correct) Curtis Bay, Md

Oct 26 1927 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See [illegible])

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Oct 28 1927

20 UNDERTAKER: Wilhelm Bros & Nadal ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

E 26758

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 26758

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1701 W. Balto ST., 19-28 WARD)

2-FULL NAME Ella M. Dunmire

(a) RESIDENCE NO. 1701 West Balto ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William-Dunmire

6 DATE OF BIRTH (month, day, and year) Feb 28-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) — 37

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Sam. Grissinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa

12 MAIDEN NAME OF MOTHER Mary McNeal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa

14 Informant Harry Ehrenfeld.
(Address) 1811 N. Fulton ave.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1927, to Oct 22, 1927, that I last saw her alive on Oct. 21, 1927, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myo-carditis
Chronic Nephritis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ---

Was there an autopsy? No.

What test confirmed diagnosis? Urinary.

(Signed) Chas. C. Corbin, M. D.

Oct. 1927 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 25 1927

20 UNDERTAKER: George J. Smith — ADDRESS: 1532 Hollins

Cor.—12-9-25—A Co.—200 Bks.

(Fox)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26759

CERTIFICATE OF DEATH.

185 E 26759

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St., [illegible] Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Nathan~~ George W. Fox

(a) RESIDENCE NO. 816 St. Paul St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Fox

6 DATE OF BIRTH (month, day, and year): 12-9-76

7 AGE — Years: 50 Months: 10 Days: 14 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: G. Fox

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Susan Seaborn

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Joseph B. Fox

(Address): 101 Wilkens St

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF ~~DEATH~~* was as follows: Fractured Pelvis + Arm (Fall - Fire Stairs Accident)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Mosser M. D.

(Coroner)

12/24 1927 (Address) 3692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Melville Leon Eldridge Date of Burial: Dec 25 1927

20 UNDERTAKER: George J. Smith ADDRESS: 153 Hollins

C. THOMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 26760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 26760

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Barclay ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia A Feldmeyer

(a) RESIDENCE No. 2013 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wallace D. Feldmeyer

6 DATE OF BIRTH (month, day, and year) Jan 10th 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis, Md (State or country)

PARENTS

10 NAME OF FATHER Henry Myers

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Julia Nubmier

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Guy Gable (Address) 2013 Barclay St, Balto

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1927

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1927, to Oct 22, 1927, that I last saw h[illegible] alive on October 22nd, 1927 and that death occurred, on the date stated above, at 8.56 m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald F Tonry, M. D.

, 19 (Address) 414 E Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Anns Annapolis Md

DATE OF BURIAL Oct 25 1927

20 UNDERTAKER B L Hopkins

ADDRESS Annapolis Md

C. HAMPSON JONES, M. D.

4 1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26761

CERTIFICATE OF DEATH.

66 E 26761

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mut Hospital 21-24 St. ____ Ward)

2-FULL NAME James Brown

(a) RESIDENCE NO. 818 Warner St. ____ Ward ____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ella Brown

6 DATE OF BIRTH (month, day, and year) Jan 14, 1893

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Allen Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Alice Yokley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Fussie Jones

(Address) 1637 Pine Street

15 Filed ____ 19__ ____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

AC Alcoholism

(duration) ___ yrs. ___ mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ___ yrs. ___ mos. 1 ds.

Oct 23rd 19 27 Signed C. E. Yates (Coroner) M. D.

(Address) 1436 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Date of Burial Oct 25 19 27

20 UNDERTAKER L. L. Brown & Son ADDRESS 101 W. Fayette

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26762

CERTIFICATE OF DEATH.

E 26762

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp, St., 1420 Ward)

REGISTERED NO. 188-003

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachael Osborn

(a) RESIDENCE NO. 1351 N. Fremont Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1876.

7 AGE: Years 51 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: General

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address) Joseph Goins 1351 N. Fremont Ave

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture of right leg. automobile accident (accidental)

(duration) yrs. mos. 5 ds.

Signed J. T. Hennessy M. D.

(Coroner)

Oct. 25 1927 (Address) 25 72 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem Date of Burial Oct 25 1927

20 UNDERTAKER Howard Easter ADDRESS 916 Mc

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26763

CERTIFICATE OF DEATH.

66 E 26763

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital 17-16 Ward)

2-FULL NAME Mary Johnson King

(a) RESIDENCE NO. 742 Bradley Ln St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert King

6 DATE OF BIRTH (month, day, and year) about 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mary Ward

(Address) 918 S. Burnaby Court

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute cerebral congestion
acute congestion of abdominal viscera (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) see other findings (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M.D.
(Coroner)

Oct. 23, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem Mt Auburn Date of Burial Oct 25 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Mc

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26764

CERTIFICATE OF DEATH.

66 E 26764

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2540 Madison St. 1359 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Johnson

(a) RESIDENCE NO. 2540 Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edw. Johnson

6 DATE OF BIRTH (month, day, and year): about 1867

7 AGE: Years: about 40 | Months: | Days: | IF LESS than 1 day.....hrs. or.....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Indiana

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address) 2540 Madison Ave.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest,

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

(Inquest, autopsy or inquiry.)

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) ..... yrs. ..... mos. 3 hours ds.

(Signed) J. F. Hennessy M. D.

(Coroner)

Oct 24, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs.. ..... mos.. ..... ds. In the State ..... yrs.. ..... mos.. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | Date of Burial: Oct 25-1927

20 UNDERTAKER: Daniel Fenton | ADDRESS: Oct 16

Spec.-7-17-26—A Co.—200 Bks.

E 26765

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26765

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 2203 E. Federal St., 8-16 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Buettner

(a) RESIDENCE NO. 2203 E. Federal St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Madalena Buettner

6 DATE OF BIRTH (month, day, and year) Aug 8-1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67.	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cigar M

(b) General nature of industry, business, or establishment in which employed (or employer) Manufacturing

(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Germany

PARENTS

10 NAME OF FATHER Buettner.

11 BIRTHPLACE OF FATHER (City or town) _____
(State or country) Unknown

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 Informant Madalena Buettner
(Address) 2203 E. Federal St

15 Filed _____, 19 _____ Registrar _____

OCT 25 1927 HAMPSON JONES, M. D. Dep

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23rd 19 27

17 I HEREBY CERTIFY, That I attended deceased from 7-15 27, to 10-27 19 27

that I last saw h[illegible] alive on 10 22 19 27

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows: Carcinoma Stomach

_____ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

_____ (duration) _____ yrs. _____ mos. 1 ds.

18 Where was disease contracted _____

If not at place of death? unknown

Did an operation precede death? No Date of _____

Was there an autopsy? No.

What test confirmed diagnosis? _____

(Signed) Frank Dyer Jr. M. D.

10-27-27 (Address) 600 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial Oct 26 1927

20 UNDERTAKER Geo W Frick & Son — ADDRESS [illegible]

Very Important. See instructions on back of certificate.

Rec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26766

CERTIFICATE OF DEATH.

E 26766

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mc Glaughlin

(a) RESIDENCE NO. 766 Mc Henry St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Chas. Mc Glaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Georgia Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Chas. Mc Glaughlin
(Address) 766 Mc Henry St

15 Filed OCT 25 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1927, to Oct 24, 1927, that I last saw him alive on Oct 24, 1927 and that death occurred, on the date stated above, at 7:00 a. m

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron S. Tull, M. D.

10/25 1927 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisonburg Va. — DATE OF BURIAL Oct. 26 1927

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 W Baltimore St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26767

CERTIFICATE OF DEATH.

128 E 26767

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 3-4 Ward)

2-FULL NAME Lewis Thomas

(a) RESIDENCE NO. 317 S Dallas St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augustus Thomas

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	~~42~~ 6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): M D

(State or country)

PARENTS

10 NAME OF FATHER: William Jones

11 BIRTHPLACE OF FATHER (city or town): M D

(State or country)

12 MAIDEN NAME OF MOTHER: un known

13 BIRTHPLACE OF MOTHER (city or town): un known

(State or country)

14 Informant: Augustus Thomas

(Address) 317 S. Dallas St

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

A C Hepatitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

19 (Address) 443 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: North Point Church Cem. Date of Burial: Oct 26, 1927

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 orleans st

Spec.–7-17-26—A Co.—200 Bks.

E 26768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124 E 26768

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1005 Aisquith St. 10th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Ph. Young

(a) RESIDENCE NO. 1005 Aisquith St. (Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. – mos. 28 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Stephen A. Young

6 DATE OF BIRTH (month, day, and year) September 20th 1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Decker

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret W. Flotta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Margaret M. Young

(Address) 1005 Aisquith St

15 Filed . 19 Registrar

OCT 25 1927

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23rd 1927

17 I HEREBY CERTIFY, That I attended deceased from November, 1926, to October 20, 1927, that I last saw h[illegible] alive on October 20, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endo-myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Oct 27 1927 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer Cemetery	Oct 26 1927
20 UNDERTAKER	**ADDRESS**
Henry Troch Son	1501 E. Eager St

Very Important. See Instructions on Back of Certificate.

Spec.—1-12-23—M&T—500 Bks. See Letter in file from Dr Miller dated Nov 3-1927

E 26769 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26769

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 E Oliver ST. 8-17 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert O Tucker

(a) RESIDENCE No. 1720 E Oliver ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Winifred Tucker

6 DATE OF BIRTH (month, day, and year) Dec. 25-1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
~~Ms~~ 92		10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paint Business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hartford (State or country) Conn

PARENTS

10 NAME OF FATHER Albert Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn

14 Informant Mrs Winifred Tucker (Address) 1720 E Oliver St

15 Filed ..... 19 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1- 1927, to Oct 23 1927, that I last saw him alive on Oct 23 1927 and that death occurred, on the date stated above, at 2 P m

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

10/24 1927 (Address) 1500 Bdway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Oct 26 1927

20 UNDERTAKER Robt J Turner Sr — ADDRESS 1344 Broadway

Spec.–7-17-26—A Co.—200 Bks.

E 26770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 26770

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Joseph's Hospital St. (or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Whalen

(a) RESIDENCE NO. 1515 N Bradford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11 - 1915

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	12	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Martin J M Whalen

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Bamberger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Annie M Whalen

(Address) 1515 N Bradford

15 Filed _____ 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct 23 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1927, to Oct 23, 1927

that I last saw him alive on Oct 23, 1927

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

~~Acute appendicitis~~

Acute appendicitis

Peritonitis

(duration) — yrs. — mos 13 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) — yrs. — mos 12 ds.

18 Where was disease contracted

if not at place of death? 1515 N Bradford

Did an operation precede death? yes Date of Oct 11 - 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) T. P. Thompson, M. D.

Oct 23, 1927 (Address) St. Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer Cemetery	Oct 27 1927

20 UNDERTAKER Robt F Turner ADDRESS 1142 Broadway

OCT 25 1927 T. C. HAMPSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26771

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

32 E 26771

REGISTERED NO.

City of BALTIMORE: (No. 1016 N. Chapel St St. 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Preston Lyle

(a) RESIDENCE NO. 1016 N. Chapel St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7th 1920

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	6	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER Ely Walker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Florance Lyle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Florance Lyle

(Address) 1016 N. Chaple St.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculoma of brain - left temp.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) O. H. Collins, M. D.

(Coroner)

10/24/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs.. ....mos.. ....ds. In the State ....yrs.. ....mos.. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Lubentz Date of Burial Oct 25 1927

20 UNDERTAKER Mrs. R. G. Elbert ADDRESS 1225 Eastland Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26772

100-09 26772

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) City Hospt St. 27-46 Ward

2-FULL NAME John Carter

(a) RESIDENCE NO. 463 Schmatz Jovan St. Ward

(Usual place of abode) Mex (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1851

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	76 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Carolina

14 Informant City Hospt.

(Address) 463 Schmatz ave.

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

Oct. 22 - 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7 o, 1927, to Oct 22, 1927, that I last saw him alive on Oct, 22, 1927, and that death occurred, on the date stated above, at 4, 45 p. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

(duration) Unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Philip Pearlstein, M. D.

Oct 22 1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Zion Cemetery Govans Oct 24 1927

20 UNDERTAKER ADDRESS

Mrs. R. A. Elliott 1125 Eastlander

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26773

CERTIFICATE OF DEATH

128 E 26773

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 210 Druid Hill St. 19th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia W. Lockerman

(a) RESIDENCE NO. 210 Druid Hill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph H Lockerman

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: Years 61 Months Days IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Washington D.C.

(State or country)

PARENTS

10 NAME OF FATHER: Wm. Woodward

11 BIRTHPLACE OF FATHER (City or town): D C

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Woodward

13 BIRTHPLACE OF MOTHER (city or town): D.C.

(State or country)

14 Informant: Alice Macbeth

(Address) 2101 Druid Hill Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct 22 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1927, to Oct 22, 1927, that I last saw her alive on Oct 22, 1927, and that death occurred, on the date stated above, at 7 20 a m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis (a)

(duration) ... yrs. 1 mos. ds.

CONTRIBUTORY Arteriosclerosis

(Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Unpublished

(Signed) S. H. Lockerman, M. D.

, 19 (Address) 120 Druid Hill Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

Date of Burial: 10/25 19 27

20 UNDERTAKER: David T. Kennedy

ADDRESS 598 W Baltimore

Spec.—1-12-23—M&T—500 Bks.

207561 E 26774

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7H-E 26774

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilly Bias

(a) RESIDENCE No. 610 Harlem ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col-

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, ~~(write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Jas L. Bias

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years 45 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Isaac Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md-

12 MAIDEN NAME OF MOTHER: Mary Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Edwards JOHNS HOPKINS HOSPITAL (Address)

15 Filed ____, 19__ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 21 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15 , 1927 , to Oct. 21 , 1927 , that I last saw h[er] alive on Oct. 21 , 1927 , and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral embolus.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Neurological.

(Signed) Herbert F. Traut, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 10/25 1927

UNDERTAKER: Edward J. Kenney

ADDRESS 578 Park

Spec.-7-17-26—A Co.—200 Bks.

E 26775

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26775

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 12-49

City of BALTIMORE: (No. ____ St., ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert S. Carter

(a) RESIDENCE NO. 100 W. 7th St. St. ____ Ward 9th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 12 ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. H. S. Carter (Mabel)

6 DATE OF BIRTH (month, day, and year): Sept. 19, 1869

7 AGE: Years 58 Months 1 Days 6 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: W D

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Orange, N. J.

(State or country)

PARENTS

10 NAME OF FATHER: Aaron Carter

11 BIRTHPLACE OF FATHER (City or town): N. J.

(State or country)

12 MAIDEN NAME OF MOTHER: Sara Swift Trow

13 BIRTHPLACE OF MOTHER (city or town): Mass

(State or country)

14 Informant: Deceased

(Address)

15 Filed ____, 19____ Per ____ Registrar

C. HAMPSON JONES

OCT 25 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Oct 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1927, to Oct. 25, 1927, that I last saw h[im] alive on Oct 25, 1927, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

After stomach operation

Fisuley hydrobiasty, + closure Ld gastro-enterostomy of

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Circulatory Failure + myocardial —

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? over

Did an operation precede death? Yes Date of Oct 22 1927

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) R. D. Telford, M. D.

10-25-1927 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York — Date of Burial: 10 25 1927

20 UNDERTAKER: J. J. Jenkins Sons Co. — ADDRESS: 9 W. Eager

Spec.—7-17-26—A Co.—200 Bks.

E 26776 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26776

CERTIFICATE OF DEATH

43

1-PLACE OF DEATH REGISTERED NO.

City of BALTIMORE: (No. 3302 Foster ave. St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J Mehring

(a) RESIDENCE NO. 3302 Foster ave St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 13th 1872

7 AGE: Years 55 Months 1 Days 20

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Michael Mehring

11 BIRTHPLACE OF FATHER (City or town): Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Katharine Eisenhauer

13 BIRTHPLACE OF MOTHER (city or town): Balto. Md.

(State or country)

14 Informant Edestine Mehring

(Address) 3302 Foster ave.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23rd 1927

17 I HEREBY CERTIFY, That I attended deceased from July 23 1927 to Oct 23 1927

that I last saw h alive on Oct 23 1927

and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Larynx.

duration 3 mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path. Laboratory

(Signed) H. E. Mc Whalen M. D.

(Address) 3308 Frank Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — Date of Burial: Oct. 26 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St

very important. See instructions on back of certificates.

OCT 25 1927 C. BAMPSON-JONES, M.D.

Spec.—1-12-23—M&T—500 Blks.

E 26777

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26777

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 W. Lexington St. St. 19-27 WARD)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Ladson

(a) RESIDENCE NO. 1518 W. Lexington St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ? mos. .? ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Ladson

6 DATE OF BIRTH (month, day, and year) July 15th. 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	30	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab. 0-10

(b) General nature of industry, business, or establishment in which employed (or employer) Construction

(c) Name of employer Morocco Co.

9 BIRTHPLACE (city or town) (State or country) Charleston S.C.

PARENTS

10 NAME OF FATHER Richard Ladson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston S.C.

12 MAIDEN NAME OF MOTHER Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charleston S.C.

14 Informant Richard Ladson (Bro)

(Address) 210 N. Strieker

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22nd , 19 27 , to Oct. 24th, 19 27 ,

that I last saw him alive on Oct 23rd , 19 27

and that death occurred, on the date stated above, at 2 A. m

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

(duration) yrs. 5 mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson , M. D.

, 19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charleston, S.C.

DATE OF BURIAL 12/2/ 19 27

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3[illegible] E. Lanvale St

Cor.—12-9-25—A Co.—200 Bks.

E 26778

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 E 26778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Enroute

City of BALTIMORE: (No. St. Josephs Hosp. St. 5-8 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~David Hall~~

(a) RESIDENCE NO. 1201 McElddery St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Moving

(c) Name of employer Libertini TransCo.

9 BIRTHPLACE (city or town)_____

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) "

14 Informant Police Dept.

(Address)

15 Filed_____, 19_____ 19_____

(4 4850) arp Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage (Fractured Skull) (Accidently fell down steps at 108 Cherry St. Essex Balto. Co.)

(duration) ____yrs. ____mos. ____ds.

CONTRIBUTORY (Secondary)_____

(duration) ____yrs. ____mos. ____ds.

(Signed) J. K. Mahon M. D.

(Coroner)

10/24/27 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death____yrs.____mos.____ds. In the State____yrs.____mos.____ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND OCT 25 1927

Spec.–7-17-26—A Co.—200 Bks.

E 26779

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26779

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Gilmore

(a) RESIDENCE NO. BALTIMORE CITY HOSPITALS St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) Friends

15 Filed ..... 19 .....

Registrar

Per 1924 ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22/1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1922, to Oct 22, 1927.

that I last saw him alive on Oct. 22, 1927

and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Lobular pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) hypertrophy of heart, chronic

(duration) 7 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Exam.

(Signed) C. Stulmo Runge M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

Very Important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND OCT 25 1927
Commissioner Health
Per Wm. E. WORNALL

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26780

CERTIFICATE OF DEATH.

154-002 E 26780

1-PLACE OF DEATH

City of BALTIMORE: (No. 1114 China St. 21-31 Ward)

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madaline Height.(C)

(a) RESIDENCE NO. 1114 China St. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	Colored	Single.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) September 28, 1927.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	0	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edward Height.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER ~~XXXXX~~ Mary Hurley.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Calvert Co. Md.

14 Informant Mary Hurley.(C) mother.

(Address) 1114 China St.

15 Filed....., 19.....

4-12-28. A.R.H. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Eberhardt M. D.
(Coroner)

10/24/27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

JOHNS HOPKINS HOSPITAL OCT 25 1927
Commissioners Health

Spec.–7-17-26—A Co.—200 Bks.

E 26781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-003

E 26781

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospitals St. 1-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Loane

(a) RESIDENCE NO. 917 Austin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 Color or Race: ~~White~~ Colored 5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 54 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 03

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country) ?

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

PARENTS

14 Informant .....

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct. 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1927 to Oct 16, 1927

that I last saw him alive on Oct. 16, 1927

and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull with Subdural Hemmorrhage (Auto accident)

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY .....

(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of Oct. 15, 27

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) ..... M. D.

. 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OCT 25 1927

UNIVERSITY OF MARYLAND

Commissioner Health.

Per Wm. E. WOODALL

1839 Now

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26782 | CERTIFICATE OF DEATH. | E 26782

REGISTERED NO._____

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. Monument St + Rutland Ave) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Bertha Weinberg.

(a) RESIDENCE NO. Darlington S. C. St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. mos. 5 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Nov. - 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51	11	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Darlington,
(State or country) S. C.

PARENTS

10 NAME OF FATHER: Abram Weinberg

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Charleston, S. C.

12 MAIDEN NAME OF MOTHER: Lizzie Isaman

13 BIRTHPLACE OF MOTHER (city or town): Marion
(State or country) S. C.

14 Informant: Dr. M. A. Weinberg
(Address) 724 Eutaw Place

15 Filed.....19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 10/25/27

17 I HEREBY CERTIFY, That I attended deceased from 10/20, 1927, to 10/25, 1927, that I last saw her alive on 10/25, 1927, and that death occurred, on the date stated above, at 1:40 A.m.

The CAUSE OF DEATH* was as follows:
Cholelethiasis
Chronic Appendicitis

(duration) 2 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Vasomotor asthenia myocardial failure.

(duration) ___ yrs. ___ mos. 1 ds.

18 Where was disease contracted
If not at place of death? Home
Did an operation precede death? Yes Date of 10/22/27.
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Lab. Tests

(Signed) D. Arthur Linde, M. D.
, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL, CREMATION OR~~ REMOVAL: Darlington, S. C. Date of Burial: 10/25/1927

20 UNDERTAKER: David Sondheim ADDRESS 118-20 W. Mt. Royal Ave

C. H. MASON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 26783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26783

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2039 N. Lafayette ave ST.) 16-22 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Graham Griffin

(a) RESIDENCE No. 2039 N. Lafayette Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth 39 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Edward B. Griffin

6 DATE OF BIRTH (month, day, and year) Aug 11. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
51	52	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Ireland

PARENTS

10 NAME OF FATHER John Graham

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ireland

14 Informant Edward B. Griffin
(Address) 2039 N. Lafayette ave.

15 Filed 25 1927, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17- , 1927, to Oct 23 , 1927 that I last saw h- alive on Oct. 22 , 1927 and that death occurred, on the date stated above, at 2.55 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

10-26 1927 (Address) 1837 Jenna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 10-26 1927

20 UNDERTAKER H. Brauning Son — ADDRESS 517 N. Edmondson Ave

Spec.—1-12-23—M&T—500 Blks.

E 26784 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 W Franklin ST. 17 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Guercio

(a) RESIDENCE No. 420 W Franklin ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 22 - 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stephen Guercio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carlina Colasanto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. D. Fodaro

(Address) 420 W Franklin

15 Filed , 19 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1927, to Oct 25, 1927, that I last saw him alive on Oct 25, 1927 and that death occurred, on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. W. Fiali M. D.

10/25, 1927 (Address) 1 Fayette Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

New Cathedral Cemetery 10/26 1927

20 UNDERTAKER — ADDRESS

George J. Ruth 1735 Harford Ave

Spec.—1-12-23—M&T—500 Bks.

E 26785 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 26785

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2081 Woodbury Ave ST., 13-57 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claus A. Neuhardt

(a) RESIDENCE No. 2081 Woodbury Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Neuhardt

6 DATE OF BIRTH (month, day, and year): May 15th 1867

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
60	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Smithsburg Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Claus A. Neuhardt (Address) 2081 Woodbury Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23rd 1927

17

I HEREBY CERTIFY, That I attended deceased from August 24 .1927. to Oct 23 .1927.

that I last saw h[illegible] alive on Oct 23 .1927

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy & Decompensation
Chronic Nephritis

(duration) yrs. 6 ? mos ds.

CONTRIBUTORY (Secondary) Mitral Disease

(duration) yrs. 6 ? mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical

(Signed) Lawrence B. Sheldon, M. D.

, 19 (Address) 412 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 10 26 1927

20 UNDERTAKER: F. M. Wyckoff

ADDRESS: 1853 W. Baltimore St

[illegible] C. HAMPSON JONES, M. D.

See Letter Attached [illegible]

Spec.-7-17-26—A Co.—200 Bks.

See Letter attached from R J Bedford Dated 11-7-27

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26786

118-001

E 26786

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

City of BALTIMORE: (No. 33rd & Cabert St., 11-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME S. Davies Warfield

(a) RESIDENCE NO. 34 E Preston St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Rose Warfield~~

6 DATE OF BIRTH (month, day, and year): Sept 4th 1859

7 AGE: Years 68 Months 1 Days 20

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pres. Seaboard Air Line R.R.

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town): Maryland

(State or country)

PARENTS

10 NAME OF FATHER Henry Warfield

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER Anna Emory

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Henry W. Warfield

(Address): 34 E Preston St

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 24 27

17

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1927, to Oct 24, 1927,

that I last saw h.... alive on 10-24, 1927,

and that death occurred, on the date stated above, at 5.45 p.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(sudden death)

(duration) ....yrs. ....mos. 0 days

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Warfield M. D.

10-24 1927 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

Date of Burial: (28 27 1927

20 UNDERTAKER: H. Fenkenbusch Co

ADDRESS: Cathedral & Mt. Vernon Pl.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HARRISON JONES, M.D.
NOV 28 1927
(U. W. SINAI HOSPITAL)

Spec.—1-12-23—M&T—500 Bks.

E 26787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-082 E 26787

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospl ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gloria S. Donnelly

(a) RESIDENCE No. 1516 N Fulton Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 19th 1927

7 AGE: Years — Months: 8 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James M Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Agnes Nash

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Mr James M Donnelly (Address): 1516 N Fulton Ave

15 Filed . . . 19 . . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927, to Oct 24, 1927; that I last saw h[illegible] alive on Oct 24, 1927; and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Norbert [illegible] M. D.

Nov 1927 (Address) 2151 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Oct 26th 1927

20 UNDERTAKER: John J Cowan & Son — ADDRESS: 901 Hollins St

Spec.—1-12-23—M&T—500 Bks.

(Moody)

E 26788

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 E Belvedere St. 27-54 WARD)

REGISTERED NO. 161-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris L Hardy

(a) RESIDENCE NO. 710 E Belvedere ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? 0 yrs. 3 mos. 1 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 27 1927

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Paul A Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ada E Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Paul A Hardy

(Address) 710 E Belvedere

15 Filed 10/28 1927 . 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1927, to Oct. 25, 1927

that I last saw her alive on Oct. 24, 1927

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Premature Gestation

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Premature Labor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) C F Humbert M.D.

10/28 1927 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem Towson — DATE OF BURIAL: Oct 27 1927

20 UNDERTAKER: Wm Cole & Sons — ADDRESS

Spec.—1-12-23—M&T—500 Bks.

1714 N. Caroline

E 26789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 26789

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 St. Paysen ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Plaenker

(a) RESIDENCE NO. 1005 St. Paysen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan- 9-1884

7 AGE — Years: 43 — Months: 9 — Days: 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick W Plaenker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Jockel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Jesse R. Lemmot. 1001 St Paysen

15 Filed 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1927, to Oct 25, 1927, that I last saw him alive on Oct 24, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Urban pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Danderson, M. D.

, 19 (Address) 1714 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Oct 28 1927

20 UNDERTAKER: William Cook — ADDRESS: 502 E Monroe

Spec.—1-12-23—M&T—500 Blks.

E 26790

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26790

CERTIFICATE OF DEATH.

+131

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Brown

(a) RESIDENCE NO. 154 "L" S.E. Wash, D. C ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced, (write the word)~~: Married

6a If married, ~~widowed, or divorced~~ ~~How long?~~ or) WIFE of Robert Brown

7 DATE OF BIRTH (month, day, and year) 1884

8 AGE: Years 43; Months ....; Days ....; If LESS than 1 day, ... hrs. or ..... min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) ..... (State or country) Virginia

10 NAME OF FATHER ——— Garnett

11 BIRTHPLACE OF FATHER (city or town) ——— (State or country) Virginia

12 MAIDEN NAME OF MOTHER ———

13 BIRTHPLACE OF MOTHER (city or town) ——— (State or country)

14 Informant Purdo JOHNS HOPKINS HOSPITAL (Address)

Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1927, to Oct. 24, 1927, that I last saw h[illegible] alive on October 24 1927, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Vesico-Vag. Fistula - operated

Endocarditis (duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Examination

(Signed) Raymond Wing ..... M. D.

10-24 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington, D. C.

DATE OF BURIAL 10/25/1927

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1638 Daniel Kirby

Spec.—1-12-23—M&T—500 Bks.

E 26791

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26791

CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3353 Falls Road ST., 13 WARD)

REGISTERED NO. 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Cook

(a) RESIDENCE No. 3353 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept. 4-1927

7 AGE: Years — Months 1 Days 20 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Hubert M. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Pearl Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hubert M. Cook 3353 Falls Road

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 24. 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 22. 1927, to Oct 24. 1927

that I last saw h[illegible] alive on Oct 24th. 1927

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Edema - (apparently no Heart or Kidney Condition)

(duration) yrs mos 7 ds.

CONTRIBUTORY (Secondary) 7 Month delivery - Weak. Badly nourished (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/24, 1927 (Address) 3604 Falls Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shrewsbury, Pa. DATE OF BURIAL: Oct. 26- 1927.

20 UNDERTAKER: Horace F. Burgee ADDRESS: 363 Falls Rd

Spec.—1-12-23—M&T—500 Bks.

E 26792

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 E 26792

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 Richmond ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Solloway

(a) RESIDENCE No. 204 Richmond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~WIFE of~~ Minnie L. Solloway

6 DATE OF BIRTH (month, day, and year) June 27, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	3 mo.	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Art Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

045

9 BIRTHPLACE (city or town) (State or country) Easton, Md

PARENTS

10 NAME OF FATHER Thos. Solloway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Shore Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

10/23 1927

14 Informant Clarence E. Solloway (Address) Catonsville, Md.

15 Filed ..... 19 ..... Registrar

1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10 , 1927 , to Oct. 23 , 1927 , that I last saw him alive on Oct. 22 , 1927 , and that death occurred, on the date stated above, at 2.20 A. m.

The CAUSE OF DEATH* was as follows:

Acute Septic Endocarditis -

From history about 3 weeks.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Embolism.

(duration) X yrs. 15 minutes.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) A. F. Robinson, M. D.

(Address) 836 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Oct 26 1927
20 UNDERTAKER	ADDRESS
Mr Mrs. John W. Tuttle & Son	80 W. Fayette

Spec.—1-19-21—M&T—1500 Bks.

E 26793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

V

75-E 26793

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3103 Belmont Ave (St.) 6-67 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Becker

(a) RESIDENCE NO. 3103 Belmont Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella V. Becker

6 DATE OF BIRTH (month, day, and year) Sept 26, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64.	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Post-Office

(c) Name of employer

009

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER August Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Peterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ella V. Becker

(Address) 605 Brunswick St.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1927.

17

I HEREBY CERTIFY, That I attended deceased from Oct 27, 1927. to Oct 23, 1927. that I last saw him alive on Oct 23, 1927. and that death occurred, on the date stated above, at 12.30 P.m.

The CAUSE OF DEATH* was as follows:

Right Side Hemiplegia

CONTRIBUTORY (Secondary) Oedema of Lungs (duration) yrs 10 mos ✓ ds.

(duration) ✓ yrs ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Phys Examination

(Signed) John L. Rathard, M. D.

10/23 1927 (Address) 1219 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL Oct 26, 1927

20 UNDERTAKER Mr. Mrs. John W. Teufel & Son ADDRESS 80 W Fayette

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26794

CERTIFICATE OF DEATH.

49 E 26794

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 30 E) Henrietta ST. 27-33 WARD)

2-FULL NAME George W. Reed

(a) RESIDENCE NO. 30 E.) Henrietta ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Reed.

6 DATE OF BIRTH (month, day, and year): Aug 22, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Self.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George W. Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Anna McGraw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant (Address): James Reed 1111 E. 31st St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1927, to Oct. 23, 1927, that I last saw h/M alive on Oct. 23, 1927, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of bladder

(duration) 1 yrs. 8 mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopy

(Signed) Kenneth D. Light, M. D.

, 19 (Address) 210 Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Oct 27 1927

20 UNDERTAKER: J. A. Kramer & Son ADDRESS: 703 Hanover St

2 OCT 1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 26795

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26795

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto City Hosp. ST., 4/29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Boston

(a) RESIDENCE NO. 1307 Lemmon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: B.

5 Single, Married, Widowed, or Divorced, (write the word): Married (Separated)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: 1

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years: 42 Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Johanna Bohn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hosp. Records

(Address): Balto City Hosp.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1927, to Oct 22, 1927

that I last saw h[illegible] alive on Oct 22, 1927

and that death occurred, on the date stated above, at 5- P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & Lab.

(Signed) C. E. Madden M. D.

10-22-1927 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: Oct 26th 1927

20 UNDERTAKER: A. Jones ADDRESS: 1[illegible] S. Gulph

Spec.–7-17-26—A Co.—200 Bks.

E 26796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 26796

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. [redacted] St. 1724 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Brandes Smith

(a) RESIDENCE NO. 5514 W. Biddle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler

(b) General nature of industry, business, or establishment in which employed (or employer) 024

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Daniels ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant

(Address) Rwnds

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

5 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20/1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1927 to Oct 20, 1927 that I last saw h. alive on Oct 20, 1927, and that death occurred, on the date stated above, at 2:00 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic + acute.
Hypostatic pneumonia
Arteriosclerosis

(duration) .. yrs. 1 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? P

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Local

(Signed) C. Hudson Boyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel, Del. Date of Burial 10/22/1927

20 UNDERTAKER Sidney Stone ADDRESS 1818 Light St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26797

CERTIFICATE OF DEATH

74 801

E 26797

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St. 426 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henningsen

(a) RESIDENCE NO. 730 East Pratt St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) ~~Married~~ Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) — — 1860

7 AGE Years 67 Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Engagement

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country) Denmark.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant M. Hosfeld (Address) 730 E. Pratt St.

15 Filed . 19 Registrar

OCT 25 1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24-27 19

17 I HEREBY CERTIFY, That I attended deceased from 10-24-27 19 , to 10-24-27 19 .

that I last saw h[illegible] alive on 10-24-27 19 .

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Respiratory failure

(duration) yrs. mos. 1 hr. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Wm Johnston , M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial 10/27 19 27

20 UNDERTAKER J. F. Fahey Home ADDRESS 1918 Eager

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26798

E 26798

CERTIFICATE OF DEATH.

REGISTERED NO. 1521-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 N Payson ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Blake

(a) RESIDENCE NO. 1526 N. Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Blake

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Fishel Rosengarten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hyttenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Joe Blake

(Address) 1526 N. Payson

15 Filed OCT 26 1927 HAROLD JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 21 1927, to Oct. 26, 1927, that I last saw h[er] alive on Oct. 25 1927, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Influenza

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical. Lab.

(Signed) R. A. Nicholson, M. D.

10/26, 1927 (Address) 2226 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 10/28, 1927

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Pitcher St

Cor.—12-9-25—A Co.—200 Bks.

E 26799

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26799

CERTIFICATE OF DEATH.

199

1-PLACE OF DEATH

City of BALTIMORE: (No.) 104 E. Rodgers Ave St., 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian D. Towers

(a) RESIDENCE NO 104 E. Rodgers Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm. G. Towers

6 DATE OF BIRTH (month, day, and year) Apr. 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	53.	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) Home Life

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry A. Croswell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabella Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Mrs Wm G. Towers

(Address) 104 E. Rodgers Ave

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull

Struck on head with a hammer

Homicidal

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) John H. Grosser M. D.

(Coroner)

10/25, 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Maryland Date of Burial Oct 26 1927

20 UNDERTAKER D. S. Marshall ADDRESS 3539 Fall Road

OCT 1927 C. HARRISON CONNER M.D.

Cor.—12-9-25—A Co.—200 Bks.

E 26800

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 E 26800

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 907 Vincent St. 16-27 Ward)

2-FULL NAME Louisa Williams

(a) RESIDENCE NO. 907 Vincent St. St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Eastern Shore Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Eastern Shore Md

14 Informant Mrs. Lelia Ackman

(Address) 907 N. Vincent St.

15 Filed_____, 19_____

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (Secondary) and Other Disease

(duration) ____ yrs. ____ mos. ____ ds.

Signed) [illegible] M. D.

(Coroner)

19 27 (Address) 557 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death____ yrs.____ mos.____ ds. In the State____ yrs.____ mos.____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Oct 26 1927

20 UNDERTAKER Virginia A Brooks ADDRESS 1463 N Carey

Per_____

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26801

CERTIFICATE OF DEATH

91-002

E 26801

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1122 Scott St. 21-29 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Gregory

(a) RESIDENCE NO. 1122 Scott St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widdowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): mar 17th 1857

7 AGE: Years 70 Months 7 Days 8

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Master 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant: Mrs Louise Davidson

(Address) 1122 Scott St

15 Filed OCT 26 1927 19 OCT 26 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 24th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21 1927 to Oct. 24 1927

that I last saw h alive on Oct 24 1927

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Artio-

Sclerosis

(duration) 1 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Asthenia & Senilitis

(duration) 1 yrs. 6 mos. 10 ds.

18 Where was disease contracted Don't know

if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hobis A. Warner M. D.

. 19 (Address) 907 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem — Date of Burial 10/29 1927

20 UNDERTAKER: Robert Brookeseson — ADDRESS Cor Calhoun Hollins Rd

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26802

CERTIFICATE OF DEATH.

129 E 26802

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 8-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wack

(a) RESIDENCE NO. 2033 Cliftwood Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) William Wack.

6 DATE OF BIRTH (month, day, and year) Oct 19 - 1887

7 AGE: Years 40 | Months - | Days 5 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. Kirschenhofer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Reinhardt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York.

14 Informant Wm. Wack

(Address) 2033 Cliftwood Ave

15 Filed ..... 19 ..... Registrar

OCT 26 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 - 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 1927, to Oct 24, 1927, that I last saw her alive on Oct 24, 1927, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Edmund Lowe, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: Oct. 27 1927

20 UNDERTAKER: George W. Zirkler — ADDRESS: 1737 E. Eager st.

Spec.—1-12-23—M&T—500 Blks.

E-26803

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26803

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Ramsay ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelm F. Meyer

(a) RESIDENCE NO. 1411 Ramsay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced (or) WIFE of / HUSBAND of

6 DATE OF BIRTH (month, day, and year) Dec 14, 1859

7 AGE: Years 67; Months 10; Days 9; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Locksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Wm. Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Mrs. J. Heigh

(Address) 1411 Ramsay St

15 Filed Oct 26, 1927 C. Hampson Jones M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1927

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1927, to Oct 23, 1927, that I last saw h[illegible] alive on Oct 22, 1927, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Egustar Dill, M. D.

10/24 1927 (Address) 1509 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Oct 26 1927

20 UNDERTAKER: Geo Lemlach Son, ADDRESS: 5207 Lyndhurst

Cor.—12-9-25—A Co.—200 Bks.

E 26804 HEALTH DEPARTMENT—CITY OF BALTIMORE 175 E 26804

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital 1124 Ward)

2-FULL NAME Charles Scott

(a) RESIDENCE NO. 1314 W. Cullen St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy Scott

6 DATE OF BIRTH (month, day, and year) Sept. 22, 1889

7 AGE	Years	Months	Days	If Less than 1 day ..... hrs. or ..... min.
	38	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Winans Hospital

9 BIRTHPLACE (city or town) Oct. 23, 192)

(State or country) Ga.

PARENTS

10 NAME OF FATHER Chas. Scott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ga.

12 MAIDEN NAME OF MOTHER Dink Kuon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dink Kuon

14 Informant Daisy Scott

(Address) 1314 W. Cullen St

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The "CAUSE OF DEATH" was as follows:

Poisoning

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds. (Ate canned sardines)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

(Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery Date of Burial 6-26 1927

20 UNDERTAKER Thomas E. Kelson ADDRESS 1303 Presstman St.

Spec.—1-10-21—M&T—1500 Bks.

E 26805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26805

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1211 E. Lexington ST., 5-8 (WARD)

2-FULL NAME Gladys Jordan

(a) RESIDENCE NO. 1211 E Lexington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 7 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	17	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER James Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md.

12 MAIDEN NAME OF MOTHER Elnore Purnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Little Fee md

14 Informant James Jordan (Address) 1211 E Lexington st

15 Filed ..., 19...

Registrar Hattie Byron Wright

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1927. to Oct 23. 1927.

that I last saw her alive on Oct 22. 1927.

and that death occurred, on the date stated above, at 3.15 a. m.

The CAUSE OF DEATH* was as follows:

Acute miliary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Tonsilitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical - X Ray.

(Signed) Bernard Harris, M. D.

(Address) 385 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Asbury Cem.

DATE OF BURIAL 10/26 1927

20 UNDERTAKER

ADDRESS 1218 Mc Elderry St

Spec.–7-17-26—A Co.—200 Bks.

E 26806

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26806

CERTIFICATE OF DEATH

47

27-54

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 7-Krebs-Av. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Calusha Heyl

(a) RESIDENCE NO. 7-Krebs-Av. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ? mos. ? ds. How long in U. S. if of foreign birth ? yrs. 1 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Earle G. Heyl

6 DATE OF BIRTH (month, day, and year) Sept-4-1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	48	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Philadelphia

(State or country) Penna

PARENTS

10 NAME OF FATHER Carman Calusha

11 BIRTHPLACE OF FATHER (City or town) unknown

(State or country) unknown

12 MAIDEN NAME OF MOTHER Susan Perrey

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country) unknown

14 Informant Earle G. Heyl (husband)

(Address) 7-Krebs-Av., City.

15 Filed ..... 19 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 22, 19 27.

17 I HEREBY CERTIFY, That I attended deceased from September, 1924, to October 22, 1927

that I last saw her alive on October 22, 1927

and that death occurred, on the date stated above, at 9 A.M. P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 3 yrs. 2 mos ..... ds.

CONTRIBUTORY General carcinomatosis
(Secondary)

(duration) 3. yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? Yes Date of November 1924

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic examination

(Signed) W. Locher, M. D.

. 19 (Address) 31 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	Oct-26-1927
20 UNDERTAKER [illegible] & SUPAN (Successor)	ADDRESS 108 W. NORTH AVE.

AUG 26 1927 C. HAMPSON JONES, M.

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26807 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26807

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2318

CITY OF BALTIMORE: (No. 2318 Eutaw Pl ST. 13-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Kras

(a) RESIDENCE NO. 2318 Eutaw Pl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of Mrs. Dora Kras

6 DATE OF BIRTH (month, day, and year) May 10-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Kras

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Dorra

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) Jacob Kras 3715 Norwood Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1927, to Oct 25, 1927, that I last saw him alive on Oct 25, 1927, and that death occurred, on the date stated above, at 5 A.M. / P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Metastasis Carcinomatosis

(duration) yrs. 6 mos ds.

18 Where was disease contracted if not at place of death? in Baltimore

Did an operation precede death? Yes Date of Oct 1/25

Was there an autopsy? no

What test confirmed diagnosis? microscopical exam.

(Signed) M. D.

, 19 (Address) 2356 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern

DATE OF BURIAL 10/26 1927

20 UNDERTAKER Jack Lewis

ADDRESS 1409 E Balto St

OCT 25 1927 C. HAMPSON JONES M.D.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26808

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26808

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No.) 636 W. Lee St. (Ward) 22-20

Registered No.

2-FULL NAME.... Russell Biddle

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 636 W. Lee St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 12-8-1902

7-AGE. 24 yrs. 10 mos. 16 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Chas Biddle

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Sadie Frazier

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14-

(Informant) Sadie Biddle

(Address) 636 W Lee St

15-

Filed ..... 192.

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 10-24-27

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1927, to Oct 24 1927, that I last saw him alive on Oct 24 1927, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonic Phthisis

(Duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm A. Cowie M. D.

, 19 (Address) 655 W Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn Cemetery — DATE OF BURIAL. Oct 27, 1927

20-UNDERTAKER. Miss Kate R. Williams — ADDRESS 327 N. Schroeder St

Spec.—1-12-23—M&T—500 Blks.

E 26809 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26809

CERTIFICATE OF DEATH. + 50

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert & 33rd St.) 12-49 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund W. Burns

(a) RESIDENCE NO. 3252 Longfellow Place (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs E. W. Burns

6 DATE OF BIRTH (month, day, and year) Aug 14 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
65	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Pres. Mo Poultry Supply Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany Maryland

PARENTS

10 NAME OF FATHER Christian Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Hench

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. E. Burns (Address) 3252 Longfellow Place

15 Filed . 19 H. A. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1927

17

I HEREBY CERTIFY, That I attended deceased from 10/23, 1927, to 10/26, 1927

that I last saw h alive on 10/26, 1927

and that death occurred, on the date stated above, at 12:30 pm

The CAUSE OF DEATH* was as follows:

Cancer of neck (Pathology and autopsy undetermined)

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/24/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James Carlton Weaver M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lowe Md	Oct 28 1927

20 UNDERTAKER Harry A. Perkins

ADDRESS Mt. Lowe Md

Spec.–7-17-26—A Co.—200 Bks.

E 26810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 131 E 26810

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Md. Gn. Hosp. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Mae Musgrove

(a) RESIDENCE NO. Knollwood, Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
		4	15 14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None, MD

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Harry Musgrove

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER Maude Brandenburg

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Howard Co. Md.

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

OCT 25 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 19 27, to Oct 26, 19 27,

that I last saw h.. alive on Oct. 26, 19 27,

and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Pyelitis - Pyonephritis

(duration) yrs. mos. ds.

CONTRIBUTORY Toxemia, Dehydration

(Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted

if not at place of death? Edmondson

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John A. Tompkins, M. D.

, 19 (Address) 1 Chas St Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

M. G. Hosp. Cem. Oct 29 27

20 UNDERTAKER — ADDRESS

Euston Sons Lafayette Ave

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26811

CERTIFICATE OF DEATH

71-001 E 26811

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Louis Hospital St., 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ray Adler

(a) RESIDENCE NO. 1115 W. Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 18 1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Butler

(State or country) Pa

PARENTS

10 NAME OF FATHER Christian Adler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Mass

12 MAIDEN NAME OF MOTHER Mary E Shotz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs William Adler

(Address) Scheton Falls. Mass

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct. 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1927, to Oct 25, 1927, that I last saw h alive on Oct. 25, 1927, and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H Lavinia Johnson, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Scheton Falls. Mass. Date of Burial Oct. 26 1927

20 UNDERTAKER George F. Rutter ADDRESS 1735 Hanford ave

Key important data. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001 V

E 26812

CERTIFICATE OF DEATH

E 26812

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St. 97-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip M. Froelich

(a) RESIDENCE NO. 4 Kenn Ave Hamilton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Froehlich

6 DATE OF BIRTH (month, day, and year): April 17 1874

7 AGE: Years 53 Months Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer —

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter J Froehlich

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary M. Froehlich

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs Philip M Froehlich

(Address) 4 Kenn ave Hamilton

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct. 24 - 1927

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1927, to Oct 24, 1927, that I last saw h[illegible] alive on Oct 24, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Toxic Goitre

(duration) yrs. 6 mos. ds.

CONTRIBUTORY Anemia

(Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? Yes Date of 10-20-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Laurence Fahrney, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bakwood Cemetery. Date of Burial: Oct. 28 1927

20 UNDERTAKER: George L. Ruth ADDRESS 1735 Harford Av

Key important: See instructions on back of certificate.

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26813

CERTIFICATE OF DEATH

162 E 26813

1-PLACE OF DEATH Hospital for Women of Maryland REGISTERED NO.

City of BALTIMORE: (No. 303 Thornhill Road St. 27-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Lee Davis

(a) RESIDENCE NO. 303 Thornhill Road St. Homeland Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	0	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Dolphin Alston Davis

11 BIRTHPLACE OF FATHER (City or town) Charlotte-

(State or country) Court House, Va.

12 MAIDEN NAME OF MOTHER Virginia Lee Hicks

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.

(State or country)

14 Informant Father (Dolphin Alston Davis)

(Address) 303 Thornhill, Rd

15 Filed ....., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct. 26, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1927, to Oct. 26, 1927, that I last saw her alive on " " , 19 27 and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

Sudden Death

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) John M. F. Bergland, M. D.

, 19 (Address) 5711 Belvedere

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Loudon Park Oct. 26 19 27

20 UNDERTAKER — ADDRESS

John C. Mitchell 1700 Eutaw Place

C. HAMILTON JONES, M. D.

1927

Very Important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 26814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 26814

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1707 N. Montford Ave. Ward) 8-16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Irene Sheckells

(a) RESIDENCE NO. 1707 N. Montford Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard J. Sheckells

6 DATE OF BIRTH (month, day, and year): Sept 17 - 1899

7 AGE — Years: 28 — Months: 1 — Days: 11

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Andrew Johnson

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Louisa Nicholson

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Howard J. Sheckells

(Address) 1707 N. Montford Ave

15 Filed ..... 19 .....

C. H. THOMPSON JONES, M. D.

6 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: October 25 - 1927

17 I HEREBY CERTIFY, That I attended deceased from September 16 1927 to October 25 1927

that I last saw h[illegible] alive on October 25 1927

and that death occurred, on the date stated above, at 8 55 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) Albert Eisenberg M. D.

Oct 28 19 27 (Address) 2005 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cem

Date of Burial: Oct 28 19 27

20 UNDERTAKER: John Ellis

ADDRESS 2 E Eden

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26815

CERTIFICATE OF DEATH

91E 26815

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1721 E Federal St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L Straub

(a) RESIDENCE NO. 1721 E Federal St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): March 21-1859

7 AGE: Years 68 Months 7 Days 3 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): NO

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: George Straub

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Rosanna Hubner

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Conrad H Pultgrafft

(Address) 1721 E Federal St

15 Filed . 19 Registrar

6 1927 C. H. [illegible] M. D.

APH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1927, to Oct 24, 1927, that I last saw h[illegible] alive on Oct 24, 1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) Edmund Lingenfelter M. D.

1927 (Address) 1613 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore, Cem. Date of Burial Oct 27 1927

20 UNDERTAKER: John Wurst ADDRESS 2008 Eutaw

Spec.—1-12-23—M&T—500 Bks.

E 26816 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26816

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 S Bond St. ST., 2-4 WARD)

2-FULL NAME Szczepan Kuc

(a) RESIDENCE NO. 839 S Bond St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 013

(b) General nature of industry, business, or establishment in which employed (or employer) Buttcher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wicenty Kuc

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Briged Zaczek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Antonina Kuc
(Address) 839 S Bond St

15 Filed ..... 19 ..... CHAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1926, to Sept 29, 1927.

that I last saw h in alive on , , 1927

and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia and Valvul Lesion of the heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. G. Freeburn, M. D.

, 19 (Address) 918 E Fayette st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary cem.	Oct 28 1927
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bond St

Spec.—6-9-19—H. P. Co.—1000 Bks.

26817

HEALTH DEPARTMENT—CITY OF BALTIMORE

26817

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1217 N. Central Ave (St.) 10-14 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kuls

(a) RESIDENCE. NO. 1217 N. Central Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 10-24-27

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Jno Hooper Kuls

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Elsie F. Mark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Middletown Md

14 Informant: Mrs Jno H. Kuls
(Address): 1217 Central Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-24 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-24 . 1927. to 10-24 . 1927.

that I last saw her alive on 10-24 . 1927.

and that death occurred, on the date stated above, at 11 0 m.

The CAUSE OF DEATH* was as follows:

Premature Labor. (6 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Jno. H. Wessler, M. D.

. 19 (Address) 4008 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL 19

20 UNDERTAKER | ADDRESS

OCT 26 1927 C. H. THOMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

E 26818

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 E 26818

CERTIFICATE OF DEATH

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Allen

(a) RESIDENCE NO. 216 N Appleton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: col

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct, 24 27

7 AGE Years Months Days 1 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Willie Allen

11 BIRTHPLACE OF FATHER (City or town) S.C.

(State or country)

12 MAIDEN NAME OF MOTHER Julia Hunter

13 BIRTHPLACE OF MOTHER (city or town) S.C.

(State or country)

14 Informant .....

(Address)

15 Filed ..... 19 .....

Registrar

1838 RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/24, 1927, to 10/25, 1927, that I last saw h.. alive on 10/24, 1927, and that death occurred, on the date stated above, at 5.4 m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

10/27, 19.. (Address) 808 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... Date of Burial ..... 19..

20 UNDERTAKER ..... ADDRESS .....

JOHNS HOPKINS HOSPITAL OCT 26 1927

C. HAMPSON JONES, M.D. Commissioner Health

Per. Wm. E. Woods

Spec.—1-12-23—M&T—500 Bks.

(Perkins)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26819

E 26819

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 570 N Stricker ST., 14-27 WARD)

2-FULL NAME Mary Perkins

(a) RESIDENCE NO. 570 N Stricker ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24 1927

7 AGE	Years	Months	Days	If LESS than 1 day / hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Edw Perkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Virginia Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Staunton Va

14 Informant Mrs. Edw. Perkins
(Address) 570 N Stricker St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1927, to Oct 27, 1927, that I last saw h[illegible] alive on Oct 24, 1927 and that death occurred, on the date stated above, at 10 P m

The CAUSE OF DEATH* was as follows:

Atelectasis Congenital
Premature birth (5 months).

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Carey, M. D.

, 19 (Address) 1500 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

OCT 28 1927 DEPARTMENT OF HEALTH

1927

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26820

CERTIFICATE OF DEATH.

198 E 26820

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospt. St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Toles

(a) RESIDENCE NO. 1623 St. Joseph St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Staford Va

PARENTS

10 NAME OF FATHER Henry Toles

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Hester Queen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Hester Toles

(Address) 1623 St. Joseph St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to incised wound of chest involving heart

HOMICIDE (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

10-24-27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Brooks Sta. Va. Oct 26, 1927

20 UNDERTAKER M. R. G. Elliott ADDRESS 1325 Ashland Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26821

118-002 E 26821

REGISTERED NO.

1-PLACE OF DEATH St Joseph's Hospital

City of BALTIMORE: (No. 27-43 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Merryman

(a) RESIDENCE NO. 12 Westview Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lennie Merryman

6 DATE OF BIRTH (month, day, and year): Feb 2 1866

7 AGE: Years 62 Months 8 Days 24 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer: H. Hollingsworth

9 BIRTHPLACE (city or town): Balt

(State or country): Md

PARENTS

10 NAME OF FATHER: Thomas Merryman

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Mehnore

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Minnie E Dobinick

(Address) 12 Westview Ave.

15 Filed ....., 19 ..... C. HUDSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1927, to Oct 26, 1927, that I last saw h alive on Oct 26, 1927, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction,

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos 10 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of Oct 20-27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H Laurence Zahniser, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial 10/28/27

20 UNDERTAKER: H. Cook — ADDRESS 502 Edmondson Ave.

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26822 ✓ HEALTH DEPARTMENT—CITY OF BALTIMORE E 26822

20

CERTIFICATE OF DEATH. X 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WALTER HAROLD BRUNNER

(a) RESIDENCE NO. 27 Balto. Av. Dundalk ST., Bal WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Baby

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-27-27

7 AGE Years: 0 Months: 3 Days: 28 If LESS than 1 day, hrs. or min.: 4 months

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~None~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland -

PARENTS

10 NAME OF FATHER: Robert Brunner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa -

12 MAIDEN NAME OF MOTHER: Anna Carvatten

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Johns Hopkins Hospital (Address)

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1927, to Oct. 25, 1927, that I last saw h[illegible] alive on Oct. 25, 1927, and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Diarrhea

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? NO Date of --

Was there an autopsy? yes

What test confirmed diagnosis? Blood studies.

(Signed) Raymond W[illegible], M. D.

10-28 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mathews Cemetery — DATE OF BURIAL: Oct 27 1927

20 UNDERTAKER: William Cook — ADDRESS: 502 E. Hoff

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26823

CERTIFICATE OF DEATH.

188-003

E 26823

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3900 Old York Road St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lee Johnson

(a) RESIDENCE NO. 3900 Old York Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia F. Johnson

6 DATE OF BIRTH (month, day, and year) Nov 8/1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Sewerage Dept.

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Phillip Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Sophia F. Johnson

(Address) 3900 Old York Road.

15 Filed 19

C. HAMPSON JONES, M. D.

1927

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Concussion of brain

(Struck by automobile Sep 30/27. On

Patapsco St nr 8th st

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Carter M. D.

(Coroner)

19 (Address) 10/25/27 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial Oct 27 1927

20 UNDERTAKER William Cook

ADDRESS 507 E North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26824 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26824

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2216 Druid Hill Ave. St. 14-59 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie Pinkett

(a) Residence No. 2216 Druid Hill Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) ? 1847

7-AGE. 80 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country), Md.

PARENTS.

10-NAME OF FATHER, David Pinkett

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Bennett

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Md.

14- (Informant). Mamie Pinkett

(Address) 2216 Druid Hill Ave

15- Filed. 1927 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 25 at 12 Midnight

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1924 to Oct. 26 1927

that I last saw h. alive on Oct. 20 1927

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Infirmities of Age

(Duration) 3 yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? 209 W Biddle St

Did an operation precede death? No Date of

Was there an autopsy? No Pathologic & Clinical findings

What test confirmed diagnosis?

(Signed) J. Bennett Lange M. D.

, 19 (Address) 2931 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cem.	10/28/1927
20-UNDERTAKER.	ADDRESS
Wm. H. Holland	1631 Druid Hill Ave

S. C. HARPER JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

JE 6 32 26825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26825

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 19-27 ST., WARD)

2-FULL NAME John R. - Quarles

(a) RESIDENCE No. 524 N. STRICKER ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1906

7 AGE: Years 21 | Months | Days | If LESS than 1 day, hrs. or min.

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labourer P.R.R.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John R. Quarles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Alice Love

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 26 1927, 19 H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-25- 1927

17

I HEREBY CERTIFY, That I attended deceased from Octo 18, 1927, to Octo 25, 1927, that I last saw h in alive on Oct. 25, 1927, and that death occurred, on the date stated above, at 2:05 p m.

The CAUSE OF DEATH* was as follows:

Acute Myeloid Leukemia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Raymond W [illegible], M. D.

10-25, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Blackstone Va — DATE OF BURIAL: Oct. 26, 1927

20 UNDERTAKER: Mrs. R.G. Elliott — ADDRESS: 1725 Cashland Ave

Spec.—1-12-23—M&T—500 Bks.

E 26826

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 E 26826

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 937 N Patterson Park Ave (WARD) 12

2-FULL NAME Emilie Willem

(a) RESIDENCE NO. 937 N Patterson Park Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, ~~widowed~~, or ~~divorced~~ (or) WIFE of Edward F. Willem

6 DATE OF BIRTH (month, day, and year) Oct 23-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Mathias Danby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Edward F. Willem

(Address) 937 N. Patterson Park Ave

15 Filed ..... , 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 24 1927

17 I HEREBY CERTIFY, That I attended deceased from February 10, 1927, to October 24 1927

that I last saw h[illegible] alive on October 24 1927

and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. H. A. Magee M. D.

10/25/27 (Address) 1031 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Oct 27 1927
20 UNDERTAKER	ADDRESS
Chas C. Miller & Son	253 S Jeffer[illegible]

1927 C. HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 26827 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 26827

94-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Vincents Infant (Hospital) (WARD)

2-FULL NAME Mary Ellen Devlin

(a) RESIDENCE No. St Vincents ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): March 17, 1927

7 AGE — Years: — Months: 7 Days: 7 If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Mary Devlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Walter C Bacon
(Address) 100 E 20th St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to Oct 25, 1927, that I last saw her alive on Oct 25, 27, 19 ..., and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 4 mos 1 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. ..... mos. 7 ds.

18 Where was disease contracted, if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Marasmus

(Signed) Walter C Bacon M. D.

10/25 1927 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 10/27/1927

20 UNDERTAKER: J. Fahey Jones

ADDRESS 131 S Eutaw St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 26828

CERTIFICATE OF DEATH.

3 | E 26828

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 W. Lafayette St. 16 Ward)

2-FULL NAME Blanche Carey

(a) RESIDENCE NO. 1104 W. Lafayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 Color or Race Col. | 5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Luther Carey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Freda Johnson

(Address) 1104 W. Lafayette

15 Filed ....., 19 C. J. LAMPSON, Jones, M. D.

Registrar

RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 19 27

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 19 27, to Oct 26, 19 27, that I last saw h[er] alive on Oct 24, 19 27, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B.

(Signed) J. Broumel, M. D.

, 19 (Address) 1139 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Oct 26 1927

20 UNDERTAKER Hunt Easton ADDRESS 916 Cathedral

OCT 26 1927

Spec.—1 12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26829

CERTIFICATE OF DEATH.

3/ E 26829

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 division ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel White

(a) RESIDENCE NO. 1123 division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE — Years: 31 — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William White

(Address) 1123 division st

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1927, to Oct 25, 1927, that I last saw h alive on Oct 25, 1927 and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Cardio Pneumonia Influenza

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Influenza Bacillus in Sputum

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Oct 26 1927

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Eutaw

ORH

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26830

CERTIFICATE OF DEATH.

100-901 E 26830

1-PLACE OF DEATH

City of BALTIMORE: (No. 810 N. Vincent St. 16-22 Ward)

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Dorsey

(a) RESIDENCE NO. 810 N. Vincent St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30, 1927

7 AGE: Years ____ Months ____ Days 5 mo 24 da | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Druid Hill

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. J. Dorsey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Bessie Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Wm. Dorsey

(Address) 810 N. V

15 Filed _____ 19____ Registrar

OCT 27 1927 C. HAMPSON JONES M.D. EHS

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. T. Kenney M. D.

(Coroner)

1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial Oct 27 1927

20 UNDERTAKER Adam Eaton ADDRESS Govans

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26831 ✓ 146 E 26831

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 Wilmot ave ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Janie Johnson Hall

(a) RESIDENCE NO. 925 Wilmot ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joe Hall

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 027

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Dead Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fanny Linville

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Joe Hall (Address) 925 Wilmot ave.

15 Filed Oct 27 1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25-1927

17

I HEREBY CERTIFY, That I attended deceased from 10/24, 1927, to 10/25, 1927, that I last saw h[illegible] alive on 10/25, 1927, and that death occurred, on the date stated above, at 10 A m

The CAUSE OF DEATH* was as follows:

Eclampsia. (over)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkett, M. D.

10/26 1927 (Address) 434 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Oct 27 1927

20 UNDERTAKER Daniel Easton & Co ADDRESS 416

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26832
1-PLACE OF DEATH

CERTIFICATE OF DEATH

91-00E 26832
REGISTERED NO.

City of BALTIMORE: (No. Sisling Sanitarium St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie J. Sumwalt

(a) RESIDENCE NO. 313 S. Stricker St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Wm. L. Sumwalt

6 DATE OF BIRTH (month, day, and year) September 13, 1842

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	85	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS
10 NAME OF FATHER James Sevier
11 BIRTHPLACE OF FATHER (City or town) Easton
(State or country) Md.
12 MAIDEN NAME OF MOTHER Elizabeth Elliott
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. James Watt
(Address) 712 N. Payson St.

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 9/2 19 27 to Oct. 26 19 27
that I last saw her alive on Oct. 26 19 27
and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Nephritis
Arteriosclerosis
(duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted Dover Town
if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) H. C. Hamilton, M. D.
(Address) 119 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial 10/28/27

20 UNDERTAKER Joseph L. Cook — ADDRESS 1003 W. Baltimore St

Very Important. See instructions on back of certificates.

10-27 1927 C. HAMPSON Jones Falls Dist

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26833

CERTIFICATE OF DEATH.

90 E 26833

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. Monument St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida Frank.

(a) RESIDENCE NO. Old Old Home St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 90 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Mrs. Sarah Cohen

(Address) 720 Asquith St.

15 Filed ....., 19 ..... Registrar

OCT 27 1927 C. HERMAN JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 10-26

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 19 27, to Oct 26, 19 27, that I last saw h-er alive on Oct 26, 19 27, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure Pulmonary Oedema

(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Hyp. disease - Arteriosclerosis

(duration) 6 yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? .....Date of.....

Was there an autopsy? .....What test confirmed diagnosis? Clinical

(Signed) Bernard Cohen, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehren Rosedale — Date of Burial 10/27 19 27

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 E Baltimore St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26834

CERTIFICATE OF DEATH

113 E 26834

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2225 Huntingdon Ave. St. 17th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa E. Peddicord

(a) RESIDENCE NO 2225 Huntingdon St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 22/1926

7 AGE — Years: 0 Months: 10. Days: 4. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant. 0/10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore city

(State or country): Maryland.

PARENTS

10 NAME OF FATHER: Thomas E. Peddicord

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Bessie Gordon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Bessie Peddicord

(Address): 2225 Huntingdon Ave.

15 Filed ..... 19 ..... Registrar

OCT 27 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1927, to Oct 26, 1927

that I last saw h[illegible] alive on ..... 19 .....

and that death occurred, on the date stated above, at 7-10 A m.

The CAUSE OF DEATH* was as follows: Hemorrhagic enteritis

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Roscoe R. Crane, M. D.

Oct 27 1927 (Address) 2438 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden — Date of Burial: 10/28/1927

20 UNDERTAKER: Ellsworth & Son — ADDRESS: 3617 Eastern Ave

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26835

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26835

CERTIFICATE OF DEATH.

11-60

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 12-50 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Ladensack

(a) RESIDENCE NO. 2801 N. Calvert St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan 9, 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
60	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Ladensack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mitelda Umlauf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna Beck Gray

(Address) Chaffee Pa

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1927, to Oct 25, 1927,

that I last saw h[illegible] alive on Oct 25, 1927

and that death occurred, on the date stated above, at 1 50 P m

The CAUSE OF DEATH* was as follows: Cardiac failure mitral acute endocarditis, lungs; following lung abscess.

(duration) ... yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 2801 N. Calvert St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Palmer F. C. Williams, M. D.

10/26/1927 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Oct 27 1927

20 UNDERTAKER Harry H Hafer

ADDRESS [illegible]

Spec.—1-12-23—M&T—500 Bks.

E 26836

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26836

CERTIFICATE OF DEATH.

+31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U.S. Marine Hosp. St. 17-51 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Parry, Harry

(a) RESIDENCE NO. ..... St., ... Ward Newport News Va

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 12 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wh	Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Sing

6 DATE OF BIRTH (month, day, and year) Sept 21, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oiler

(b) General nature of industry, business, or establishment in which employed (or employer): Marine

(c) Name of employer: U.S. Western Ocean

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: John Parry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Esthonia

12 MAIDEN NAME OF MOTHER: Elizabeth Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Esthonia

14 Informant (Address): Hospital Records U.S. Marine Hosp

15 Filed ....., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/17/ 1927 to 10/25/ 1927 that I last saw him alive on 10/25/ 1927 and that death occurred, on the date stated above, at 1 50 A m

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary Chronic

Several (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yorktown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hosp Laboratory

(Signed) J. Ralph Thornton M. D.

(Address) U.S. Marine Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary Hampton

DATE OF BURIAL 10/27 1927

20 UNDERTAKER: E LeRoy Stoffle

ADDRESS 155 Main

Spec.—1-12-23—M&T—500 Blks.

E 26837 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26837

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hosp. ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Washington, Paul

(a) RESIDENCE No. 1418 Mount St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estelle Johnson

6 DATE OF BIRTH (month, day, and year) April 19, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	26	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deck Hand

(b) General nature of industry, business, or establishment in which employed (or employer) Steam Ship

(c) Name of employer U.S. Nantisco

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Ed Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.

12 MAIDEN NAME OF MOTHER Rezuria Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant U.S. Marine Hosp. Records (Address) 21st St Wilmington Del

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/21/, 1927, to 10/27/, 1927, that I last saw him alive on 10/24/27, and that death occurred, on the date stated above, at 2.55 p m

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

about 7 yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Oct 28 1927

20 UNDERTAKER E. LeRoy Loffler

ADDRESS 1255 North Ave

Spec.—1-12-23—M&T—500 Bks.

E 26838 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26838

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 N. Caroline ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Harrison

(a) RESIDENCE NO. 721 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Warren Harrison

11 BIRTHPLACE OF FATHER (city or town) Edisto
(State or country) N. C

12 MAIDEN NAME OF MOTHER Beatrice Williams

13 BIRTHPLACE OF MOTHER (city or town) Edisto
(State or country) S. C.

14 Informant Father - Warren Harrison
(Address) 721 N. Caroline

15 Filed Oct 27 1927 C. HAMPSON JONES, [illegible]
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1927, to Oct 25, 1927, that I last saw h— alive on Oct 25, 1927, and that death occurred, on the date stated above, at 11:20 m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Auto Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Berry, M. D.

, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury

DATE OF BURIAL Oct 27 1927

20 UNDERTAKER John W Henderson

ADDRESS 1502 E. Monument

Spec.—1-12-23—M&T—500 Bks.

E 26839

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 26839

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1217 N. Washington ST. 8-13 WARD)

2-FULL NAME Mary Martha Smith

(a) RESIDENCE No. 1217 N. Washington ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John E. Smith

6 DATE OF BIRTH (month, day, and year): March 11 1854

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
68	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Stewartstown Pa

PARENTS

10 NAME OF FATHER: Thomas J. Hendrix

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Rebecca Austein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Mr. Thomas M. Smith
(Address) 13 Halcyon Park Road.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1927, to Oct 26, 1927, that I last saw h[er] alive on Oct 26, 1927, and that death occurred, on the date stated above, at 8 45 A.M.

The CAUSE OF DEATH* was as follows: Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) F. E. Hoarder, M. D.

Oct. 26, 1927 (Address) 1301 N Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stewartstown Pa — DATE OF BURIAL: Oct 29 27

20 UNDERTAKER: W. M. Fickner Sons — ADDRESS: North Pa

Spec.—1-12-23—M&T—500 Bks.

E 26840

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 26840

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Wyman Park Opts

CITY OF BALTIMORE: (No. To be Assigned Ave. 12-49 WARD)

2-FULL NAME Fannie Smith

(a) RESIDENCE NO. Wyman Park Opts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua M. Smith

6 DATE OF BIRTH (month, day, and year) Dec 1- 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ..

(c) Name of employer ..

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Louis Twisto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Cecelia Twisto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Miss Lillian Smith

(Address) Wyman Pk Opts

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1927

17 I HEREBY CERTIFY, That I attended deceased from ~~Oct~~ 4, 1927, to Oct 26, 1927, that I last saw her alive on Oct 25, 1927 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cardio. Nephritis

(duration) 3 yrs — mos — ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Wm Love, M. D.

Oct 28 1927 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem — DATE OF BURIAL Oct 28 1927

20 UNDERTAKER Thos J Jenkins Son — ADDRESS Baltimore

OCT 28 1927 C. HAMPSON JONES, REGISTRAR

Spec.–7-17-26—A Co.—200 Bks.

E 26841

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26841

CERTIFICATE OF DEATH

24-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3108 Harford Road St. 9-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bartholomeus Stoecker

(a) RESIDENCE NO. 3108 Harford Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S. if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Margaret Stoecker

6 DATE OF BIRTH (month, day, and year): Not Date

7 AGE: Years 80 | Months — | Days — | IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: John Stoecker

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town): Not Known

(State or country)

14 Informant: Mrs. Robert A. Norris

(Address): 3108 Harford Ave

15 Filed ..., 19 ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19th 1927 to Oct. 26th 1927

that I last saw him alive on Oct. 26th 1927

and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemmorrhage

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary): Causa

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted: —

If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert A. Stark M. D.

10/26 1927. (Address) 3126 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: Oct. 29 1927

20 UNDERTAKER: Henry Wood & Son — ADDRESS: 1301 E Eag[illegible]

very important. See instructions on back of certificates.

OCT 27 1927 C. HAMPSON JONES, M.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26842

CERTIFICATE OF DEATH.

90 E 26842

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2404 Race St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgania Dixon

(a) RESIDENCE NO. 2404 Race St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Col	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. C.

PARENTS

10 NAME OF FATHER Wiley Sumner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Wiley Rivers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Scott Edmonds

(Address) 2704 Race St

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (autopsy or inquiry) find that said deceased came to death on the day stated above.

18 CAUSE OF DEATH* was as follows:

Tabular Disease of Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
(Coroner)

10/26 1927 (Address) 3902 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Oct 27 1927

20 UNDERTAKER Daniel Easter & Son ADDRESS 946

OCT 27 1927 C. HAMPSON JONES

Spec.—1-12-23—M&T—500 Bks.

E 26843 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26843

CERTIFICATE OF DEATH.

65-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2238 Pa ave ST. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rader

(a) RESIDENCE No. 2238 Pa ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F ~~M~~	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2 57

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick Rader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kraft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant Mrs Anna Rader

(Address) 2238 Pa ave

15

Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1927

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to Oct 25, 1927, that I last saw ~~her~~ alive on Oct 25, 1927, and that death occurred, on the date stated above, at 6-30 Am.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ~~—~~

Did an operation precede death? no Date of ~~—~~

Was there an autopsy? no

What test confirmed diagnosis? Blood

(Signed) J M S Love M. D.

Oct 26 1927 (Address) 836 W North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodstock cemetery

DATE OF BURIAL Oct 27 1927

20 UNDERTAKER W M Routson

ADDRESS 2238 W North

Spec.—12-9-25—A Co.—200 Bks.

E 26844

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 26844

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH

City of BALTIMORE: (No. 618 W. Franklin St. 17-25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Murphy

(a) RESIDENCE NO. 618 W. Franklin St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Murphy

6 DATE OF BIRTH (month, day, and year): Sept 28 – 1882

7 AGE: Years 45 | Months — | Days 27 28 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer): 59 0

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER: Martin J. Murphy

11 BIRTHPLACE OF FATHER (city or town): Balto.

(State or country)

12 MAIDEN NAME OF MOTHER: Jane Clark

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland

14 Informant: Elizabeth Murphy

(Address) 618 W. Franklin St

15 Filed ....., 19 ..... C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 25th 1927

17:

I HEREBY CERTIFY, That I attended deceased from Oct. 24- 1927 to Oct. 25- 1927, that I last saw h— alive on Oct. 24- 1927, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) ..... yrs. ..... mos. 1 ds. 2m

CONTRIBUTORY (Secondary) (1) Acute Cardiac Dilatation 2d (2) Gastro-intestinal Hemorrhage (3) Carcinoma Cancer 3 days

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) H. W. Pinkett, M. D.

10-26. 1927 (Address) 1 St Paul.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial 10/28 1927

20 UNDERTAKER: Chas. R. Maul & Son ADDRESS 118 W. Mt. Royal Ave

Spec.–7-17-26—A Co.—200 Bks.

E 26845

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 E 26845

CERTIFICATE OF DEATH

1-PLACE OF DEATH Budget O'Donnell

City of BALTIMORE: (No. St. Joseph's Hospital St. Ward)

REGISTERED NO. 1044

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 233 E. Preston St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (Write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Unknown

7 AGE: Years 72 Months — Days — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland

(State or country)

PARENTS

10 NAME OF FATHER John O'Loud

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen O'Loud

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Margaret Quinn

(Address) 733 E. Preston St

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26. 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 19 27, to Oct 26, 19 27, that I last saw her alive on Oct 26, 19 27, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Lawrence Fahrney, M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Calvary Cemetery

Date of Burial: 10/29 1927

20 UNDERTAKER: Chas. P. Crane

ADDRESS: 1130 W. Fayette

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26846 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26846

131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 S. Curley ST. 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman B. Holstein

(a) RESIDENCE NO. 11 S. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. — mos. — ds. How long in U. S., if of foreign birth? 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed.

If married, widowed, or divorced HUSBAND of (or) WIFE of Clara E Holstein

6 DATE OF BIRTH (month, day, and year) Jul 19th 1845

7 AGE Years 82 Months 5 Days 6 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Herman B. Holstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland.

14 Informant Mary Reis

(Address) 11 S Curley

15 Filed ...., 19 Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 1-27 to Oct 25-1927

that I last saw him alive on Oct 24-27

and that death occurred, on the date stated above, at 8.05 Pm

The CAUSE OF DEATH* was as follows:

Pyelo-Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman B Herman M.D.

19 (Address) 7113 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West View Redeemer DATE OF BURIAL Oct 28th 1927

20 UNDERTAKER F.D. Mayfield ADDRESS 1850 W Balto St

Spec.–7-17-26—A Co.—200 Bks.

E 26847

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26847

49

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Trybulowski

(a) RESIDENCE NO. 1100 S. Linwood St. 2 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE: Years 21 Months Days

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Multigraph Operator

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Joseph Trybulowski

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Antonette

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant (Address) From City Hospital Balto Md

15 Filed ....., 19.... Registrar

C. HUMPSON JONES

OCT 27 1927

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1927 to Oct. 24, 1927

that I last saw him alive on Oct. 24, 1927

and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Osteo Sarcoma Lower End of Right Femur Metastasis

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W Blickbeil M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westlawn Cem

Date of Burial: Oct 27 1927

20 UNDERTAKER: Stephen J Fitzhugh

ADDRESS: Wenn Ave

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26848

CERTIFICATE OF DEATH.

67-002

E 26848

1-PLACE OF DEATH

City of BALTIMORE: (No. 3 West Belvedere Ave. St. 45-11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank B. Shanck

(a) RESIDENCE NO. 1567 Clifton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret E Shanck

6 DATE OF BIRTH (month, day, and year): Jan 27 1862

7 AGE: Years 61 Months 9 Days 29

IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Barrett Co

9 BIRTHPLACE (city or town): Balto Co

(State or country): Md

PARENTS

10 NAME OF FATHER: Jarett Shanck

11 BIRTHPLACE OF FATHER (city or town): Balto Co

(State or country): Md

12 MAIDEN NAME OF MOTHER: Emily Barney

13 BIRTHPLACE OF MOTHER (city or town): Balto Co

(State or country): Md

14 Informant (Address): Margaret E Shanck 1567 Clifton Ave

15 Filed ....., 19 .....

Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the date stated above.

The CAUSE OF DEATH* was as follows:

Benzol Poisoning

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Fibrous Pneumonia

(duration) yrs. mos. 6 ds.

(Signed) A. T. Hemmeter M. D.

(Coroner)

Oct 27, 19 27 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

Date of Burial 10/29/27 19

20 UNDERTAKER: William Bolton

ADDRESS: E Madison

Spec.—1-12-23—M&T—500 Blks.

E 26849 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26849

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 W Lexington ST. 8-17 WARD)

2-FULL NAME Sabina D Payne

(a) RESIDENCE NO. 2025 W Lexington ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry A Payne

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) [illegible]

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant (Address) Mrs Carrie Hagen 2025 W Lexington St

15 Filed ..., 19 ... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept 19th, 1927, to Oct 25th, 1927, that I last saw her alive on Oct 25th, 1927, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. W. Harrington M. D.

(Address) 1401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 28 1927

20 UNDERTAKER Wm Cook — ADDRESS 501 E Mad

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26850

CERTIFICATE OF DEATH.

90 E 26850

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 657 Fait Av St. 26-37 Ward)

2-FULL NAME Antoni Paul

(a) RESIDENCE NO. 657 Fait St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Paul.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: About 68 Years Months Days. IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Australia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Frank L. Paul.

(Address): 657 Fait Ave

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, as Autopsy or Inquiry.

Thereon and from the evidence obtained by said Injury I do find that said deceased came to Death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ex Laustrup

(duration) ..... yrs. ..... mos. ..... ds.

Oct 26 19 27 (Signed) G. C. Wades M. D.

(Address) 143 W. 1st Stray (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

Date of Burial: 10/28 19 27

20 UNDERTAKER: [illegible]

ADDRESS: 522 Elliott St

OCT 27 1927 T. HAMPSON JONES, M.

Cor.—12-9-25—A Co.—200 Bks.

E 26851 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26851

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Died in City Ambulance on Washington Blvd on 11th Ward

City of BALTIMORE: (No. ~~to Hospital~~ St., 13th Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Perry

(a) RESIDENCE NO. 3035 Westwood Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 8 Unknown 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About 65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R R

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Jas. H. Perry

11 BIRTHPLACE OF FATHER (city or town) England

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Ann E. Bubby

13 BIRTHPLACE OF MOTHER (city or town) England

(State or country) Unknown

14 Informant Wm Boerner

(Address) 3035 Westwood Ave

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy 1 hr

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos B. Norton M. D.

Oct 26 1927 (Address) Curtis Bay, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Oct 27 1927

20 UNDERTAKER M. Linnie Sons Inc ADDRESS 3111 Spaldings Lane

Key Important: See Instructions on Back of Certificate.

Spec.—1-12-23—M&T—500 Blks.

E 26852 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26852

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Bentalou St. 11-6 WARD)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Hardingham

(a) RESIDENCE NO. 1005 North Bentalou ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A Hardingham Sr

6 DATE OF BIRTH (month, day, and year): Apr 16-1870

7 AGE: Years 57 Months 6 Days 10 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert Wagert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): John A. Hardingham Sr 1005 N. Bentalou

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1927, to Oct. 26, 1927, that I last saw h[illegible] alive on Oct 25, 1927 and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH* was as follows:

Chr. myelitis - hypertension

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? P.E. & Lab.

(Signed) Edmund L. Dodd, M. D.

1927 19 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 10/29 1927

20 UNDERTAKER: Geo. Weber & Son — ADDRESS: 2503 Edmondson

OCT 27 1927 C. HAMPSON JONES, M.D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26853

CERTIFICATE OF DEATH.

E 26853

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Edew ST., 5-4 WARD)

2-FULL NAME Thomas H. Boldew

(a) RESIDENCE NO. 412 N. Edew ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Boldew

6 DATE OF BIRTH (month, day, and year) Aug. 4th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Centerville Md.

PARENTS

10 NAME OF FATHER Henry Boldew

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Cora Boldew (Address) 412 N. Edew St

15 Filed . 19 Registrar

C. HAMPSON JONES, M.D. OCT 27 1927 C.H.J.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1927, to Oct 24, 1927, that I last saw h alive on Oct 24, 1927, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) yrs. mos. ds.

Chronic interstitial Nephritis

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis (duration) yrs. 7 mos. 18 ds.

Contributory Secondary

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive

(Signed) Dr Gutheridge M. D.

10-27-1927 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

20 UNDERTAKER Byron & Wright

DATE OF BURIAL 10/27 1927

ADDRESS 218 N Eutaw St

Spec.—1-12-23—M&T—500 Bks.

E 26854 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26854

160

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Dunst al ST 11-4-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Smith

(a) RESIDENCE NO. 1209 Dunst al ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-18-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John J. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Edna Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr Smith
(Address) 1209 Dunst. al.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/20, 1927, to 10/26, 1927,

that I last saw him alive on 10/25, 1927

and that death occurred, on the date stated above, at 10.30 A. m

The CAUSE OF DEATH* was as follows:

Asthenia

(duration) yrs. 0 mos 7 ds.

CONTRIBUTORY (Secondary) — Family Feeding

(duration) yrs. mos. 4 wks. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

10/26, 1927 (Address) 1099 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 10/28 1927

20 UNDERTAKER S. F. McCully

ADDRESS 130 S. Fra

Spec.—1-10-21—M&T—1500 Bks.

E 26855 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26855

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital.

CITY OF BALTIMORE: (No.) Calhoun & Fayette Sts. (Ward) 24-23

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Berg.

(a) RESIDENCE NO. 1135 Battery Ave ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs life mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 13, 1927.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer): ppd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER Frank Berg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Regina McMahon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mother.
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1927, to Oct. 26, 1927,
that I last saw h alive on Oct. 26, 1927,
and that death occurred, on the date stated above, at 3:50 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal indigestion with diarrhea.

(duration) yrs. mos 10 days

CONTRIBUTORY (Secondary) otitis media

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Elizabeth Sherman, M. D.

, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters

DATE OF BURIAL: 10/28/1927

20 UNDERTAKER: J. F. McAuley

ADDRESS: 1202 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

E 26856 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 26856

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 10-15 Ward)

2-FULL NAME Gloria Senna

(a) RESIDENCE NO. 1615 Warden Ave St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26/27

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
			6 hrs	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Nicholas Senna

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Fork

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant
(Address)

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity - 7 mons gest ation

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Baltz M. D.
(Coroner)
, 19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Greenmount Oct 27 1927

20 UNDERTAKER Thos. F. Carbon ADDRESS 1906 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

E 26857 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26857

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 4-26 Ward)

2-FULL NAME Edward Jales

(a) RESIDENCE NO. 318 Myrtle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Lillian Jales

6 DATE OF BIRTH (month, day, and year): 7 25 1893

7 AGE — Years: 34 — Months: 3 — Days: 0 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): So Carolina

PARENTS

10 NAME OF FATHER: Richard Jales

11 BIRTHPLACE OF FATHER (city or town)

(State or country): So Carolina

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Lillian Jales

(Address) 318 Myrtle ave

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and hour) Oct 25 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) Lifetime yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

Signed: G C Glade M. D.

(Coroner)

10-27-27 (Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary & city — Date of Burial: 10-27-1927

20 UNDERTAKER: Geo T. C. Gibson — ADDRESS: 1735 Druid Hill Ave

Spec.—1-12-23—M&T—500 Blks.

E 26858 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26858

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1314 Fremont ST. 14-20 (WARD)

REGISTERED NO. 16606

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malcolm G. Dowell

(a) RESIDENCE No. 1314 Fremont ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 13/24

7 AGE: Years 3 | Months 5 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm G Dowell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ala Co Md

12 MAIDEN NAME OF MOTHER: Mary Nesbitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A. Co Md

14 Informant: Wm G Dowell
(Address): 1314 Fremont

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/25 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/25, 1927, to 10/25, 1927, that I last saw him alive on 10/25, 1927, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dysentary

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustav Goldman, M. D.

, 19 (Address) 1016 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cemetery

DATE OF BURIAL: Oct 27 1927

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Hesselton

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26859

CERTIFICATE OF DEATH.

90 E 26859

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 28 W. Gibbons Ave (St.) (Ward) 27-44

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Deegan

(a) RESIDENCE NO. 28 W. Gibbons Ave St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 24, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William P. Deegan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant ..... (Address) S. R. Mears 805 N. Calvert St.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1926, to Oct. 27, 1927, that I last saw h[illegible] alive on Oct. 26, 1927, and that death occurred, on the date stated above, at 4.50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

several years
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. M. Bacon, M. D.

, 19 , (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patrick's Cemetery	10/29 1927

20 UNDERTAKER Henry U. Mears & Son ADDRESS 805 N. Calvert

1927 C. HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26860

CERTIFICATE OF DEATH.

161 E 26860

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Garrington

(a) RESIDENCE No. 209 East ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 22 1927

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		one	7 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Garrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Lura Milton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Otto Mekkam M. D.
(Address) Johns Hopkins Hospital

15 Filed ..... 19 ..... By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1927, to Oct. 23, 1927,

that I last saw her alive on Oct. 23, 1927,

and that death occurred, on the date stated above, at 4 20 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Otto McKinney, M. D.

10-25 1927 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
C. HAMPSON JONES, M. D.

OCT 27 1927

Commissioner Health

Per [illegible]

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26861

CERTIFICATE OF DEATH.

100-001

E 26861

1-PLACE OF DEATH

City of BALTIMORE: (No. 1109 Laurens St. 16-20 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arnold Frank Roy

(a) RESIDENCE NO. 1109 Laurens St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 5, 1927

7 AGE Years Months Days: 21 | If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): (none)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address): W. W. Dist. Pratt Emma. Md.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) no other cause

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. T. Hamilton, M. D.

(Coroner)

Address 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL | Date of Burial 19

20 UNDERTAKER | ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26862

CERTIFICATE OF DEATH.

90 E 26862

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Lafayette Ave & Pulaski Hwy Ward)

2-FULL NAME Unknown

(a) RESIDENCE NO. Unknown St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): Don't Know

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Don't Know

6 DATE OF BIRTH (month, day, and year): about 1885

7 AGE — Years: about 42 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Don't Know

(b) General nature of Industry, business, or establishment in which employed (or employer): 089

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address): W. W. Police Station Edmondson Ave.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 19 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. T. Hennessy M. D.

(Coroner)

19 27 (Address) 2071 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Very Important. See Instructions on Back of Certificate.

UNIVERSITY OF MARYLAND
THE ROBERT C. HEMPSON JONES COLLECTION
Per Wm. B. Hoddal

Cor.—1-12-28—M&T—100 Bks.

E 26863 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26863

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 W. Lexington St. 18-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sylvia [illegible]

(a) RESIDENCE NO. 925 W. Lexington St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed , 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.*

The CAUSE OF DEATH* was as follows: Pul T. B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Oct 7-27 (Signed) Jos Cullen Bladen M. D. (Coroner) 192 (Address) 143 W 73 ray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
Commissioner Health.
THE MARRIAGE

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26864

CERTIFICATE OF DEATH

38 E 26864

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 23-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Slater

(a) RESIDENCE NO. 160 W. Hamburg St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Slater

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant

(Address) Records.

15 Filed ....., 19 .....

Registrar

1813 RPR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/23/1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927 to Oct 23, 1927, that I last saw him alive on Oct 23, 1927 and that death occurred, on the date stated above, at 10.45 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic vacute
Interstitial Syphilis
Cutaneus clensis. Contrac
Manus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General & Sub

(Signed) C. Stedman Bond, M. D.

, 19 (Address) CITY HOS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26865

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/ E 26865

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (T.B.) ST., (WARD)

2-FULL NAME Elmer Julius

(a) RESIDENCE NO. 241 W. Preston st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hazel Rosetta Julius

6 DATE OF BIRTH (month, day, and year) 1892 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Julius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1927

17

I HEREBY CERTIFY, That I attended deceased from July 21 1927, to Oct. 24, 1927,

that I last saw him alive on Oct. 24, 1927

and that death occurred, on the date stated above, at 7.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 year 3 mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Diagnosis

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10-25-27, 19 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Spec. -7-17-26—A Co.—200 Bks.

E 26866

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26866

CERTIFICATE OF DEATH

11-09

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2101 Woodbury Ave. 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy A. Swartz

(a) RESIDENCE NO. 2101 Woodbury Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 4 1914

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	13	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Alberton

(State or country) Maryland

PARENTS

10 NAME OF FATHER: Russell Swartz

11 BIRTHPLACE OF FATHER (City or town): Brown Town

(State or country) Virginia

12 MAIDEN NAME OF MOTHER: Cassie Cameron

13 BIRTHPLACE OF MOTHER (city or town): Brown Town

(State or country) Virginia

14 Informant: Russell Swartz

(Address) 2101 Woodbury Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 25 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 19 27, to Oct 25, 19 27,

that I last saw h.. alive on Oct 25, 19 27,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted? At home

If not at place of death?

Did an operation precede death? No Date of Sept. 27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Simon F. Kelly M. D.

11/27, 1927 (Address) 4 Somerset Terr

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Good Shepherd Cem. Date of Burial Oct. 28 27

20 UNDERTAKER: Easton Sons & Ellicott ADDRESS

very important. See instructions on back of certificates.

Agnes C. THOMPSON JONES M. D.

27 1927

Spec.—1-12-23—M&T—500 Bks.

E 26867

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5602 Garrison Ave. (Ward) 7-56 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Mary Glenn

(a) RESIDENCE No. 5602 Garrison Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (Husband's or) (w) WIFE of Thomas Glenn

6 DATE OF BIRTH (month, day, and year) 2-20-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Patrick Horrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Do Not Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Mrs) Reed Miller (Address) 5602 Garrison Ave.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1927

17

I HEREBY CERTIFY, That I attended deceased from ..... 1924 to Oct 25 1927, that I last saw h[illegible] alive on Oct 24 1927 and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 3 or 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred B Jewett, M. D.

Oct 26 1927 (Address) 25-16 Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL 10-28-27, 19

20 UNDERTAKER: Mather Fahey & Sons — ADDRESS 18 W. Mt. Royal Ave.

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26868

CERTIFICATE OF DEATH.

E 26868

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 923 East 30th ST. 9-41 WARD)

2-FULL NAME Lizzie J. Neuweiler

(a) RESIDENCE NO. 923 East 30th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George F. Neuweiler

6 DATE OF BIRTH (month, day, and year): Feb 16 1867

7 AGE: Years 60 Months 8 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D C

PARENTS

10 NAME OF FATHER: Joseph Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Ella G. Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Geo. F. Neuweiler 930 E - 30th

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 12, 1927, to Oct 26, 1927, that I last saw her alive on Oct 25, 1927, and that death occurred, on the date stated above, at 8:50 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma (of breast)
(non malignant tumor from Feb-1924 to Mar-1927)

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct 26, 1927 (Address) 2438 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Oct 28 1927

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

27 HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 26869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 26869

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1515 John ST., 14-20 (WARD)

2-FULL NAME Ann Jennett

(a) RESIDENCE NO. 1515 John ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 55 yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick Jennett

6 DATE OF BIRTH (month, day, and year): Oct. 17, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	95	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER Henry Randal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant: Miss Mary Jennett

(Address) 1515 John Street

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 26, 1927, that I last saw h[illegible] alive on Oct 26 1927, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Claudius, M. D.

(Address) 1501 Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 10/28 19 27

20 UNDERTAKER: Henry U. Mears & Son

ADDRESS: 805 N. Calvert

OCT 27 C. HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

E 26870

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-007 E 26870

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1606 E Clement St. 24-35 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Unnamed, Baby (Frank McHale)

(a) RESIDENCE NO. 1606 E Clement St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 10.26.27

7 AGE: Years | Months | Days: 36 hrs | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Francis J McHale

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: Helen Theresa Frank

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Francis J McHale

(Address): 1606 E Clement St

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10.27 1927

17

I HEREBY CERTIFY, That I attended deceased from 10/26 1927, to 10.27, 1927, that I last saw h[illegible] alive on 10/27, 1927, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis 1 hour

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E J Shorlington, M. D.

10/27 1927 (Address) 1026 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Marie Cem. Towson Date of Burial Oct 27 1927

20 UNDERTAKER: Margaret J. Flynn ADDRESS: 1422 Light St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2064 464 E 26871 — X 100-001 — E 26871

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) JOHNS HOPKINS HOSPITAL 1-4

2-FULL NAME Perry N. Porter

(a) RESIDENCE No. Aurora, W. Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced, (write the word)~~: Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Feb. 28 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	74	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sara Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Bessie ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1927, to Sept. 27, 1927, that I last saw h[illegible] alive on Sept. 27, 1927, and that death occurred, on the date stated above, at 7:03 a. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 4 yrs. (?) mos ..... ds.

CONTRIBUTORY (Secondary) Pyelo-nephrosis - cystitis
Broncho Pneumonia - Infarct of Lung
(duration) ..... yrs. 4 weeks (?) mos. ..... ds.

18 Where was disease contracted if not at place of death? Home (?)

Did an operation precede death? Yes Date of Sept 15, 1927

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) William M. Millar, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairbank Md. — DATE OF BURIAL: Oct 28 1927

20 UNDERTAKER: Wm Dickerson — ADDRESS: North [illegible]

Spec—12-23-21—E.B.R.S.—400 Bks.

Mary Curee

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26872 E 26872

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

City of BALTIMORE: (No. 105 W. York St. 22-30 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Curee

(a) Residence No. 105 W. York St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Col	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct. 3rd 22

7-AGE. yrs. 22 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. Longie Curee

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Denton Md.

12-MAIDEN NAME OF MOTHER. Mary Pulibett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Denton, Md.

14. (Informant) Mary Curee

(Address) 105 W. York St

15-

Filed 192

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 25 21

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21 1921 to Oct 25 1921

that I last saw h[illegible] alive on Oct 23 1921

and that death occurred, on the date stated above, at 11.4 m.

The CAUSE OF DEATH* was as follows:

Gastro intestinal Auto-intoxication

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. 22 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. H. Connor M. D

10/26 1921 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Zion	Oct 28 1921

20-UNDERTAKER.	ADDRESS
D. L. Brown & Son	1011 W. North Ave

FOR 1921 [illegible]

D W G

Spec.—1-12-23—M&T—500 Blks.

E 26873

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26873

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 814 Dumont (ST.) 79-48 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena L Smith

(a) RESIDENCE NO. 814 Dumont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jon L. Smith

6 DATE OF BIRTH (month, day, and year): Oct 20 1854

7 AGE: Years 73 Months 8 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Philip Raschert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary E. Reinheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr Henry Mengle

(Address): 814 Dumont Ave

15 Filed ..., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 19 26 to Oct 27, 19 27, that I last saw h~~e~~ alive on Oct 27, 19 27 and that death occurred, on the date stated above, at 2:50 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) 1 yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chron Int. Nephritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Thos J Kelly M.D., M. D.

19 (Address) 43 Bonaparte Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pt Carmel

DATE OF BURIAL: 10 29 19 27

20 UNDERTAKER: J. Cox

ADDRESS: 77 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

E 26874 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26874

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Masonic Temple (Char St. (1st) Ward 9-45 84

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Heller

(a) RESIDENCE NO. 3116 Harford Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Heller

6 DATE OF BIRTH (month, day, and year) Dec 20/1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Designer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Casper Heller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna R. Herap

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Wife

(Address)

15 Filed....., 19.... Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25/1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure - Angina Pectoris

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) J. H. Wallis M. D.

(Coroner)

10-27, 1927 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Oct 29 1927

20 UNDERTAKER George W. Zirkler ADDRESS 1737 E. Eager St

Very Important. See instructions on back of certificate.

C. HAMPSON JONES, M.D.

Cor.—1-12-23—M&T—100 Bks.

E 26875 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26875

CERTIFICATE OF DEATH.

41-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 McHenry St 21-29 STS WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Joseph Lee

(a) RESIDENCE NO 702 McHenry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 89 yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13th 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer Retired Oct

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John H Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A.Co Md

12 MAIDEN NAME OF MOTHER Susan Hodges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) AA Co Md

14 Informant Mrs Wm H Carlin

(Address) 417 Quincy St N.W Wash. D.C.

15 Filed OCT 28 1927 192 H A Lee Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(Duration) yrs. Not Known mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

Oct 27 1927 (Signed) G E Slades (Coroner) M. D.

(Address) 743 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Oct 28 1927

20 UNDERTAKER Henry A Jenkins & Sons ADDRESS McCulloh

Asst. and St.

Spec.—12-4-25—A Co.—200 Bks.

E 26876 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 26876

CERTIFICATE OF DEATH.

160

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. So. Balt. Gen. Hosp. St. 8-12 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Stickler (No. 2)

(a) RESIDENCE NO. 2317 E. Chase St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 24, 1927

7 AGE: Years | Months | Days | IF LESS than 1 day hrs. or min. 2 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) So. Balt. Gen. Hosp.

(State or country)

PARENTS

10 NAME OF FATHER Leroy J. Stickler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Simmons

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant

(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Oct. 25, 1927

17 I HEREBY CERTIFY, That I attended deceased from 5 35 AM Oct. 24, 1927 - Oct 25, 1927 @ 2 A.M.

that I last saw h[illegible] alive on at 2 AM Oct 25 19 27,

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows: Insufficient Vitality

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Pskarny, M.D.

, 19 (Address) 2200 E Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carnegie Embryological Labs. Date of Burial

20 UNDERTAKER: Madison & Wolff Sts ADDRESS

...tant. See instructions on back of certificates.

OCT 28 1927 C. HARTSON JONES, Pet

Spec.—12-6-25—A Co.—200 Bks.

E 26877

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26877

160

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. So. Bal. Gen. Hospital (St.) 8-12 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Stickler (No. 1)

(a) RESIDENCE NO. 2317 E. Chase St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 24. 1927

7 AGE	Years	Months	Days	IF LESS than 1 day 15 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) So. Balt. Gen. Hosp.

PARENTS

10 NAME OF FATHER Leroy F Stickler

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Simmons

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Maryland

14 Informant

(Address)

15 Filed _____, 19 _____ H. A. _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1927

17 I HEREBY CERTIFY, That I attended deceased from 4 05 A M, 19 _____, to 6 50 P M Oct 24-27

that I last saw him alive on _____, 19 _____,

and that death occurred, on the date stated above, at 6 50 P m.

The CAUSE OF DEATH* was as follows:

Insufficient Vitality

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Pokorny M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Carnegie Embryological Laboratory 19

20 UNDERTAKER ADDRESS

Madison & Wolfe St

very important. See instructions on back of certificates.

Spec.—1-12-27—M&R—5000.

E 26878

E 26878

207765

161-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1927 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CLARENCE FEUCHTENBERGER

(a) RESIDENCE No. 351 S. Woodyear St. ST. WARD H.&H.To

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced. (write the word): Baby

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14-1927

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
12 Days	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: A 12 day patient

(b) General nature of industry, business, or establishment in which employed (or employer): at baby

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: CLARENCE FEUCHTENBERGER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: ANNIE DALWIGNEY

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Friends JOHNS HOPKINS HOSPITAL (Address)

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1927, to Oct. 27, 1927, that I last saw him alive on Oct. 27, 1927, and that death occurred, on the date stated above, at 4^00 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of Oct 27, 1927

Was there an autopsy? No

What test confirmed diagnosis? Inspection, Autopsy

(Signed) H. C. Sturgeon, M. D.

10/27, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Oct 29 1927

20 UNDERTAKER: Thos Fields 1200 N Lombard — ADDRESS

C. HANSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26879

CERTIFICATE OF DEATH.

E 26879
REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No. Sinai Hospital St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Cohan

(a) RESIDENCE NO. 810 Whitelock St St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Benj Cohan

6 DATE OF BIRTH (month, day, and year) May 20 1891

7 AGE: Years 36 Months 5 Days 7 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) New York

PARENTS

10 NAME OF FATHER Ephrain Frank
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia
12 MAIDEN NAME OF MOTHER Mary Cohen
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Benj Cohan
(Address) 810 Whitelock St

15 Filed....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 - 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1927, to Oct 27, 1927, that I last saw h.r alive on Oct 27, 1927, and that death occurred, on the date stated above, at 9:25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 5 yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Dr. Geo J. Heyer, M. D.
, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew Cem. Date of Burial 11-8-1927

20 UNDERTAKER: Jack Levin ADDRESS 1435 E Baltimore St

very important. See instructions on back of certificates.

Spec.—1-12-25—M&T—500 Bks.

E 26880

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 26880

CERTIFICATE OF DEATH.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3224 Edgate ST. 26-37 WARD)

2-FULL NAME George Miller

(a) RESIDENCE No. 3224 Edgate ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 7, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Maria Stemmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant John H. Miller (Address) 3224 Edgate St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26 , 1927 to Oct. 26 , 1927 that I last saw him alive on Oct. 26 , 1927 and that death occurred, on the date stated above, at 10 12 P. m.

The CAUSE OF DEATH* was as follows:

Anoulsam
Acute Bronchitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Chas Kenworthy, M. D.

, 19 (Address) 2579 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Cemetery — DATE OF BURIAL Oct 29 1927

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Pleasant St

Spec.–7-17-26—A Co.—200 Bks.

E 26881

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26881

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 45 Forrest Ave., Hillsdale St. 28-65 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Popp

(a) RESIDENCE NO. 45 Forrest Ave., Hillsdale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Martin Popp

6 DATE OF BIRTH (month, day, and year) August 8, 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	68	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) ...

(State or country) Germany

PARENTS

10 NAME OF FATHER George Wertz

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Altmen

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country) Germany

14 Informant Miss Marie C. Popp

(Address) 45 Forrest Ave., Hillsdale

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Oct 26, 1927, that I last saw her alive on Oct 25, 1927, and that death occurred, on the date stated above, at 12.50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis About 3 yrs (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis about 1 (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted ...

if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Hallo S Willett, M. D.

Oct 26 1927 (Address) 2220 Garrison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial 10/28/27

20 UNDERTAKER Joseph L Cook — ADDRESS 1007 W. Baltimore St

very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

E 26882 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26882

CERTIFICATE OF DEATH. 112

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1641½ Cary St. 15-21 WARD)

2-FULL NAME Olivia Saunders

(a) RESIDENCE No 1641½ Cary ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4th 27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Samuel Turner

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Saunders

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Louisa Saunders
(Address) 1641½ Cary St.

15 Filed OCT 28 1927 C. HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Gastro - Enteritis

(duration) yrs. mos. 5 ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Oct. 27, 192 7 (Address) 2572 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Moriah	Oct 29 192 7
UNDERTAKER	ADDRESS
Hawe Gamse Edelstein	1641 Cary

Spec.—1-12-23—MAT—500 M.

E 26883

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26883

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2936 E. Fayette ST. 6-11 WARD)

2-FULL NAME Mary A. McDonough

(a) RESIDENCE NO. 2936 E. Fayette ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ (or) WIFE of Wm. J. McDonough

6 DATE OF BIRTH (month, day, and year) May - 1857

7 AGE Years 70 Months 5 Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John O'Malley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Feldon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jno. McDonough 2936 E. Fayette St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1927

17 I HEREBY CERTIFY, That I attended, deceased from Oct 23, 1927, to Oct 26, 1927.

That I last saw her alive on Oct 25, 1927

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Coma —

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

10/27 19 27 (Signed) A. W. White D., M. D. (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL 10/27 19 27

20 UNDERTAKER J. J. Moran ADDRESS 300 E. Baltimore

OCT 28 1927

Spec.—1-10-21—M&T—1500 Bks.

E 26884 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 809 S. Third ST. (or) WARD) 22-31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Sullivan

(a) RESIDENCE NO. 809 S. Third ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Francis M. Sullivan

6 DATE OF BIRTH (month, day, and year): Nov. 17th 1875

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
52	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Frank Hoeger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katharine Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Francis M. Sullivan (Address) 809 S. Third St.

15 Filed 1927, 19 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 26th 1927

17 I HEREBY CERTIFY, That I attended deceased from 6/10, 1927 to 10/26, 1927.

that I last saw h[er] alive on 10/22, 1927,

and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Anaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. O. Gurell M. D.

19 27 (Address) 630-S-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: Oct 29 1927

20 UNDERTAKER: Lilly + Zeiler — ADDRESS: 403 6 Wolfe

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

E 26885

CERTIFICATE OF DEATH.

E 26885

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital 26-39 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annetta Robusta

(a) RESIDENCE NO. 1001 N 9th St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1927

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
6 mo	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) ....

(State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Michael

11 BIRTHPLACE OF FATHER (city or town) ....

(State or country) Italy

12 MAIDEN NAME OF MOTHER Annetta

13 BIRTHPLACE OF MOTHER (city or town) ....

(State or country) Italy.

14 Informant ....

(Address)

15 Filed.....19____ 1850 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10-27-27

17

I HEREBY CERTIFY, That I attended deceased from 10-21, 19 27, to 10-27, 19 27, that I last saw her alive on 10-27, 19 27 and that death occurred, on the date stated above, at 12 10A m.

The CAUSE OF DEATH* was as follows:

Bilateral Bronchio-Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted

If not at place of death? ....

Did an operation precede death? ....Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) Harry Weintraub, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND
Commissioner Health

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26886 (2 copies) E 26886

CERTIFICATE OF DEATH.

REGISTERED NO. 1610

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 3-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sampson

(a) RESIDENCE NO. 714 E. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-14-27

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
—	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nathaniel Sampson

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Lily Sampson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... 1856 ARA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1927, to Oct 26, 1927, that I last saw her alive on Oct 26, 1927, and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 1 mos 12 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Allan Blagrom, M. D.

10/26, 1927 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL C. HARTMAN KELLY, JR. Commissioner of Health OCT 28 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26887

CERTIFICATE OF DEATH

E 26887

1-PLACE OF DEATH University Hospital. 16-64 REGISTERED NO. 57

City of BALTIMORE: (No. ..... S. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katie Buttenfield.

(a) RESIDENCE NO. 1000 Asburton St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	52	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore md

PARENTS

10 NAME OF FATHER Otto Baumann

11 BIRTHPLACE OF FATHER (City or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Mary Bragg

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) md

14 Informant Wm D. Buttenfield

(Address) 1000 Asburton St

15 Filed ..... 19 ..... Registrar

C. HAMPSON [illegible] M. D.

OCT 28 1927

Per NRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 27, to October 27, 19 27.

that I last saw her alive on October 26, 19 27,

and that death occurred, on the date stated above, at 7.40 am.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis.

(duration) yrs. 9 mos. 6 ds.

CONTRIBUTORY (Secondary) Hydrothorax, Diabetes mellitus

Cardiac insufficiency

(duration) yrs. 9 mos. 6 ds.

18 Where was disease contracted

If not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & laboratory

(Signed) John Roberts Phillips, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Run — Date of Burial Oct 28 19 27

20 UNDERTAKER Niemt Carton — ADDRESS 916 Park ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26888

129

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 520 Lambert ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Downs

(a) RESIDENCE NO. 520 Lambert ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	C	Widower

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Sarah Downs

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Yards

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md

PARENTS

10 NAME OF FATHER Don't Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know.

12 MAIDEN NAME OF MOTHER Don't Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know.

14 Informant Grace Downs (Address) 520 Lambert St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 1927, to Oct 27 1927, that I last saw h~~im~~ive on Oct 26 1927, and that death occurred, on the date stated above, at 10 39 ~~P~~ A. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Jane Brown, M. D.

1927 (Address) 1837 Druid Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL Oct 30 1927

20 UNDERTAKER David Easton

ADDRESS 516 N. Eutaw

Spec.–7-17-26—A Co.—200 Bks.

E 26889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-01

E 26889

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Providence Hospital St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Edmond

(a) RESIDENCE NO. 617 W. Mulberry St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 8 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE: Years 50 Months — Days —

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER W. E. Edmond

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Dill Koon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dill Koon

14 Informant Minnie Edmond

(Address) 617 W Mulberry St

15 Filed..... 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from 10/25 19 27 to 10/26 19 27

that I last saw him alive on 10/26 19 27

and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John W. Garrett M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

Date of Burial: Oct 28 1927

20 UNDERTAKER: David Burton

ADDRESS 916 Pa ave

OF DEATH in plain terms. Do not use abbreviations or the names of diseases which are not properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26890 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26890

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 12-51 ST. Peregoy WARD)

2-FULL NAME Lucy Vowles Peregoy

(a) RESIDENCE NO. 26 W 25th St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Elmer Peregoy.

6 DATE OF BIRTH (month, day, and year) Feb, 21, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	68	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thomas Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Louisa Garner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant William E. Peregoy
(Address) 26 W. 25th St.

15 Filed OCT 28 1927 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 27 1927 to Oct 28 1927.

that I last saw her alive on Oct 27 1927

and that death occurred, on the date stated above, at 2 40 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis +

Diabetes Mellitus - Myocarditis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bl. chemistry.

(Signed) Palmer F. C. Wilson, M. D.

10/28/1927 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	10/31 1927

20 UNDERTAKER Chas. L. Cook

ADDRESS 1000 N. Baltimore St

THIS IS VERY IMPORTANT—See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 26891

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26891

CERTIFICATE OF DEATH

113

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph Cockerill

(a) RESIDENCE NO. 407 W. Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
June 21, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Ralph Cockerill

11 BIRTHPLACE OF FATHER (City or town) Elkins
(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Nellie Koon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) W. Va.

14 Ralph Cockerill
407 W. Baltimore St.

15 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927
October 28,

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1927, to Oct 28, 1927, that I last saw h[illegible] alive on Oct 27, 1927, and that death occurred, on the date stated above, at 4.45 a.m.

The CAUSE OF DEATH* was as follows:

Enterbis (3 weeks duration)
Mucous Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

7 days (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Abraham H. Turkelstaub, M. D.

10/29 19 27 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Elkins, W. Va.

Date of Burial 10/29/27 19

20 UNDERTAKER Harold Cook

ADDRESS 1003 W. Baltimore St.

Spec.—1-12-23—M&T—500 Bks.

2E 26892 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26892

JOHNS HOPKINS HOSPITAL

CERTIFICATE OF DEATH. + 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST., 7-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Metto

(a) RESIDENCE No. Hollins Va ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident: give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sallie Metto

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Friend (Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 16, 1927, to Oct 28, 1927, that I last saw him alive on Oct 28, 1927, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

1 Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Brain tumor

Glioma (?) (duration) yrs. 2-3 mos.? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct. 17, 1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Smith, M. D.

10-28-27 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodville Va DATE OF BURIAL Oct 28 1927

20 UNDERTAKER C. Easter ADDRESS Fun Bunion

Spec.—12-9-25—A Co.—200 Bks.

E 26893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+91-902 E 26893

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Morrow

(a) RESIDENCE NO. 211 Inglesides ave St. Catonsville Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 68 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Ireland

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (city or town)
(State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) " "

14 Informant Edward Cusack
(Address) 211 Inglesides Ave

15 Filed....., 19.....
DFW Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28 - 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 9-17, 1927, to 10-28, 1927, that I last saw him alive on 10-28, 1927, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis and Gangrene
Amputation of leg
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Generalized Arterio Sclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? yes Date of 9-19-27.
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) P. D'Adaglieria, M. D.
, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial: New Cathedral Cem Oct 31 19 27.

20 UNDERTAKER Easton Son Ellicott City — ADDRESS

very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 26894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 E 26894

1-PLACE OF DEATH

City of BALTIMORE: (No. 41 E. Hamilton Ave St., 27-44 Ward)

Registered No.

2-FULL NAME Sarah Jane Kennedy

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 41 E. Hamilton Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write this word.) Widowed

5a-If married, widowed, or divorced (HUSBAND of or) WIFE of Alexander Kennedy

6-DATE OF BIRTH (month, day and year) Feb-11-1847

7-AGE. 80 yrs. 8 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland.

PARENTS.

10-NAME OF FATHER, Michael Chesler

11-BIRTHPLACE OF FATHER (city or town) (State or Country) England Baltimore Maryland.

12-MAIDEN NAME OF MOTHER, Hannah Crosland.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England.

14- (Informant) Annie J. Kennedy

(Address) 41 E. Hamilton Ave

15- Filed ..... 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 27 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 27" 1927 10 am to 5 P m to ..... 19....

that I last saw her alive on October 27 19 27

and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden (Duration) ..... yrs. ..... mos. Hours ..... ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) 3 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb W. Athey M. D.

Oct 28, 1927 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery — DATE OF BURIAL. Oct-29 1927

20-UNDERTAKER. Hughes & Jones Inc — ADDRESS 424 W Broadway

Instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 26895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 26895

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1324 Washington Blvd St. 21-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma R. Carlisle

(a) RESIDENCE NO. 1324 Washington Blvd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Carlisle

6 DATE OF BIRTH (month, day, and year) December 3, 1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	42	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Henry Schrader

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Eliza Lye

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Thelma King

(Address) 4 N. Carey St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1927, to Oct 25, 1927, that I last saw h[illegible] alive on Oct 25, 1927, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Balto Md.

Did an operation precede death? Yes Date of May 27

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) J. J. Kaltenbach, M. D.

, 19 (Address) 2306 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt-Carmel Cemetery	Oct 29, 1927
20 UNDERTAKER	ADDRESS
Jos Joerales + Son	217 S. Paca

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

28 1927 C. HARRISON JONES, M. D.

MRH

Spec.—1-12-23—M&T—500 Bks.

20 E 2646

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26896

REGISTERED NO. E 26896

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 1-9 ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MURRAY A. BOND

(a) RESIDENCE NO. Odenton, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~ Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: Mary L. Bond

6 DATE OF BIRTH (month, day, and year): March 19 1885

7 AGE: Years 42 Months 7 Days 8 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: CHARLES BOND

11 BIRTHPLACE OF FATHER (city or town) (State or country): Illinois

12 MAIDEN NAME OF MOTHER: Mary MARTIN

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Wards JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..., 19 ... Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1927, to Oct-27, 1927, that I last saw him alive on Oct. 27, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart disease ?

? coronary occlusion.

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Non tubercular pul. infection (duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Raymond Wing, M. D.

10-27, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Oct 29 1927

20 UNDERTAKER: Chenowet Elson 3415

ADDRESS: Edmondt Ave

TION IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26897

CERTIFICATE OF DEATH.

90 E 26897

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3012 Westwood Ave ST., 15-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Hughes

(a) RESIDENCE No. 3012 Westwood ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer): at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: John Boulden.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Boulden.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Carrie Alexander

(Address) 3012 Westwood ave.

15 Filed ..... 7 ..... , 19 27 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27. 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Oct 27, 1927, that I last saw her alive on Oct 27, 1927, and that death occurred, on the date stated above, at 11 55 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Pulmonary edema

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. C. Trumbo, M. D.

, 19 (Address) 4 E Biddle st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery Md.	10/30. 1927.

20 UNDERTAKER: Lemmon & Son 361 Eastern ave.

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 26898

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26898

CERTIFICATE OF DEATH.

X 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 9-45 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Mary Monahan

(a) RESIDENCE NO. Lansdowne. Md ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred non Resident yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 10, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lansdowne Md

PARENTS

10 NAME OF FATHER James E. Monahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Agnes Trombley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Agnes Monahan
(Address) Lansdowne Md

15 Filed ... 19 ... Registrar

10-28-1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Oct 27, 1927, that I last saw h[illegible] alive on Oct 27, 1927 and that death occurred, on the date stated above, at 4 15/60 m.

The CAUSE OF DEATH* was as follows:

Gonorrheal Opthalmia

(duration) yrs. 3 mos 5 ds.

CONTRIBUTORY (Secondary) Gastroenteritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Myron G. Tuck, M. D.

10/28. 1927 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL Oct 29 1927

20 UNDERTAKER John J Cowan & Son. ADDRESS 901 Hollins St

THION is very important. See instructions on back of certificate.

Spec.—1-12 23—M&T—500 Blks.

E 26899 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26899

CERTIFICATE OF DEATH.

REGISTERED NO. 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 704 W Saratoga ST. 11 (WARD)

2-FULL NAME Emma A. Franklin

(a) RESIDENCE NO. 704 W Saratoga ST., .. WARD ..

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Thomas Franklin

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE 52 Years — Months — Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. N. Franklin (Address) 704 W Saratoga St

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 26 1927, to Oct 26 1927, that I last saw her alive on Oct 25th 1927, and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Paralysis of the Spine resulting from a fall, in falling broken & rupping of the spinal cord about the region of lumbo-sacral enlargement.

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Asthenia followed by Carc R. Tuberc

(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) C. Maxwell Hinds M. D.

10/27 1927 (Address) 119 W Franklin Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Oct 28 19 27

20 UNDERTAKER Samuel Hennessy ADDRESS Middle

10/28 1927 C. HAMPSON JONES, M. D.

THIS is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26900

CERTIFICATE OF DEATH.

90 E 26900

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospl. St., 17-25 Ward)

2-FULL NAME Mary Crawson

(a) RESIDENCE NO. 502 Druid Hill Ave St.____ Ward____

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Macey Crawson

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Balto City Hospl

(Address) Balto Md

15 Filed_____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26/27

17 I HEREBY CERTIFY, That I attended deceased from 9/22/27, 19____, to 10/26/27, 19____, that I last saw her alive on 10/25/27, 19____, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Senile & Exhaustive Psychoses

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of____

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Philip Pearlstein, M. D.

10/26, 1927 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norlina N.C. Date of Burial 10/28 1927

20 UNDERTAKER Paul T. Hensley ADDRESS 578 W Biddle

very important. See instructions on back of certificate.

Co.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26901

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

183 ✓ E 26901

REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St. 2-4 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence Murphy

(a) RESIDENCE NO. 2056 Bank St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12/1923

7 AGE	Years	Months	Days	IF LESS than 1 day..... hrs. or.....min.
	4	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) child

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Penna.

PARENTS

10 NAME OF FATHER John Murphy

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Penna

12 MAIDEN NAME OF MOTHER Margaret Sonner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penna

14 Informant Lilly & Zeller

(Address) 403 S Wolfe St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: in chest

Hemorrhage - accidently shot by his brother while playing with old gun Oct 22/27.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Weber M. D.

(Coroner)

19 (Address)

10-28/27. 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Cemetery Date of Burial

Hokendauqua, Lehigh Co. Pa Oct 31/27

20 UNDERTAKER Lilly & Zeller ADDRESS 403 S. Wolfe

Oct 28 1927 C. Harrison Jones M. D.

EKS

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26902

CERTIFICATE OF DEATH.

74-001

E 26902

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1105 Harlem Ave. Ward 46-26)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Alston

(a) RESIDENCE NO. 1105 Harlem Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Alston.

6 DATE OF BIRTH (month, day, and year): About 1858

7 AGE: Years 69 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): General

(c) Name of employer: self

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Mrs. James Alston

(Address) 1105 Harlem Ave.

15 Filed ..... 19 .....

Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) no other history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Oct 26 1927 (Address) 9572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial Oct 30, 27

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Hanover

OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 29 1927 C. HARRISON, M.D.

George W. Kemp

Spec.-7-17-26—A Co.—200 Bks.

George W. Kerner

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26903

CERTIFICATE OF DEATH

90

E 26903

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Balto City Hospital 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo W Kerner

(a) RESIDENCE NO. 208 N Kenwood Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 13/64

7 AGE: Years 63 Months 8 Days 14

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER Geo A Kerner

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Sophia

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Geo. H. Kerner

(Address) 2632 W. Eldorado

15 Filed ..... 19 .....

OCT 29 1927 C. HAMPSON JONES

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1927 to Oct 27, 1927

that I last saw him alive on Oct 27, 1927

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis

Chronic Myocarditis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical Exam

(Signed) [illegible] M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. Date of Burial 10/31/27

20 UNDERTAKER: Philip Herrig ADDRESS 2016 Orleans

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 26904 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26904

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4902 Porter Heights and ST. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R Ford

(a) RESIDENCE NO. 4902 Porter Heights ST., Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 28, 1851

7 AGE: 75 Years | Months 11 | Days 29 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Sea Captain

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Worster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John C. Ford (Address) 1 St Charles Ave near Hoffman

15 Filed ....., 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1927, to Oct 27, 1927, that I last saw him alive on Oct 26, 1927, and that death occurred, on the date stated above, at 9.20 A m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) yrs. 6 mos 7 ds.

CONTRIBUTORY (Secondary) Work Hardening (No Evidence of Arteriosclerosis) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Clinical Evidence

(Signed) E. D. Lucas, M. D.

10-27 1927 (Address) 5736 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel C. A. 60 Md. | DATE OF BURIAL 10/30/27

20 UNDERTAKER: Philip Henry | ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26905

CERTIFICATE OF DEATH.

129 ✓ E 26905

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mun Hosp. St. 16-22 Ward)

2-FULL NAME Samuel Allen

(a) RESIDENCE NO. 1527 Winchester St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX — | 4 Color or Race Mail Colored | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE Years 30 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Am Kriane

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Minnie Allen

(Address) 1527 Winchester St

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
Pulmonary Oedema Due to Nephritis
Alcoholic
(Duration) yr. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Oct 29/27 (Signed) G C Stadt M. D.

(Coroner)

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death... yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Greenmount Cem. Oct 30 1927

20 UNDERTAKER — ADDRESS

Daniel Easton 916 Park Ave

OCT 29 1927 C. HUMPHREYS Jr. M.D.

Cor.—12-9-25—A Co.—200 Bks.—Exact statement of OCCUPATION is very important. See instructions on back of certificate. If DEATH in part results, or that it may be properly classified.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26906

CERTIFICATE OF DEATH.

90 E 26906

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1911 Cor Norwood + Oldford Ave St. 28-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace M. Burgess

(a) RESIDENCE NO. 1911 Cor Norwood + Oldford Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo A Burgess

6 DATE OF BIRTH (month, day, and year) July 31 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Gilbert C Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ella E Kuth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Edward E Williams

(Address) 1911 Cor Norwood Ave

15 Filed 1927 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no other reason

(duration) yrs. mos. ds.

(Signed) D. T. Hennessy M. D.

(Coroner)

Oct 27, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn Cemetery	Oct 29 1927

20 UNDERTAKER	ADDRESS
Harry J Armacost	1204 Ridge Ave

OF DEATH IS plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 26907 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26907

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~1610~~ Park ave ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Stewart Davidge

(a) RESIDENCE NO. 1610 Park Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~not Wife of~~ Mabel W. Davidge

6 DATE OF BIRTH (month, day, and year) June 13-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54 years		4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Walter Dorsey Davidge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant Mrs Mabel W Davidge
(Address) 1610 Park ave

15 Filed OCT 29 1927 19.. C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28th 1927

17

I HEREBY CERTIFY, That I attended deceased from ..... 19 18 ., to Oct 28th 1927 .

that I last saw him alive on Oct 28th 1927 ,

and that death occurred, on the date stated above, at 1145 A m.

The CAUSE OF DEATH* was as follows:

Sub-acute parenchymatous nephritis

(duration) 9 yrs. 1 ~~mos~~ ~~ds~~

CONTRIBUTORY (Secondary) Pulmonary oedema, acute

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) E. H. Nuttall M. D.

10-28 1927 (Address) 1515 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Oct 31 1927

20 UNDERTAKER: John B. Spence — ADDRESS: 1325 N Caroline St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 26908

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 26908

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 3030 Phila. Road St. 6-11 Ward).

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Pasquale Cazone~~

(a) RESIDENCE NO. 3030 Phila Road St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Cazone

6 DATE OF BIRTH (month, day, and year) December 19/86

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Michael Cazone

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Emanuela Torcher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Elizabeth Cazone

(Address) 3030 Phila Road

15 Filed_____, 19_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) H H Bolton M. D.

(Coroner)

10/29/37 (Address) 509 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the state ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Date of Burial Oct 31 1937

20 UNDERTAKER Wendell Diffenbaugh ADDRESS 37 Wash

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 26908

Cor.—12-9-25—A Co.—200 Bks.

E 26909 HEALTH DEPARTMENT—CITY OF BALTIMORE 112 E 26909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1525 W. Lexington St. 4th Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Neal

(a) RESIDENCE NO. 1525 W. Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stella Neal

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Tom Neal

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Miranda Williams

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Stella Neal

(Address) 1038 N. Gilmor St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and upon Inquest, autopsy or inquiry and thereon and from the evidence obtained by Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

24 hours (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

Thos. B. Horton M. D.

Oct 28 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem Date of Burial Oct 31st 1927

20 UNDERTAKER: A. Jones ADDRESS: 111 S. Gilmor St

Only classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 29 1927 C. HANSON JONES

Spec.—1-12-23—M&T—500 Bks.

E 26910 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26910

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 N Caroline ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Violet A. Z. Jackson

(a) RESIDENCE NO. 618 N Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of Randall Jackson

6 DATE OF BIRTH (month, day, and year) March 19, 1853

7 AGE Years 74 Months 7 Days 6 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel M. Grayson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co Md.

12 MAIDEN NAME OF MOTHER Mary Sheppard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Algernon M. A. Jackson 618 N Caroline St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 27, 1927, that I last saw h er alive on Oct 26, 1927 and that death occurred, on the date stated above, at 8 10 A. m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis
& Anasarca

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) unknown mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

10/28 1927 (Address) 1429 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 10.31 1927

20 UNDERTAKER Rhoda C. White

ADDRESS 1133 W. Lafayette Ave

C. HAMPSON JONES, M. D.

OCT 29 1927

HON IS very important. See instructions on back of certificates.

CF—1926—A Co—200 Bks.

E 26911

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26911 ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 327 So. Paroh St. 19-26 Ward)

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Shirley M. Earley

(a) RESIDENCE NO. 327 So. Paroh St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11 1927

7 AGE — Years: — Months: 1 Days: 17

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Samuel Earley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Freter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant (Address) Samuel Earley 327 So. Paroh St

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by Inquiry (Inquest, autopsy or inquiry)

find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Indigestion

(duration) yrs. mos. ds.

Oct 28 1927 Signed Thos. B. Horton M. D. (Coroner)

(Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. For additional space see back.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: Oct 29 1927

20 UNDERTAKER: Harry A. Witzke ADDRESS: 1531 W Lombard St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 23 1971 CHARLTON JONES, M.D.

Spec.—1-12-23—M&T—500M

E 26912

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26912

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 N Bond St. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adrian Hunstow

(a) RESIDENCE NO. 633 N Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) April 1916

7 AGE: Years 11 Months 6 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Edward Hunstow

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Alice Gregg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Edward Hunstow, father 633 N Bond st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1927, to Oct 27, 1927, that I last saw h[im] alive on Oct 26, 1927, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) apprx 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Hemmorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

10/28/1927 (Address) 1417 Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Agothy A. A. Co. Md — DATE OF BURIAL 10/30 1927

20 UNDERTAKER: Byron Wright — ADDRESS 1218 Mc Elderry st

TION is very important. See instructions on back of certificate.

OCT 29 1927 C. HAMPSON JONES, M.

Spec.—12-9-25—A Co.—200 Bks.

E 26913 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26913

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1034 Vine St. 18-16 Ward)

2-FULL NAME Frank Glover

(a) RESIDENCE NO. 1034 Vine St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced. (write the word): Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen Glover

6 DATE OF BIRTH (month, day, and year): Unknown 1887

7 AGE: Years 40 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): _____

(State or country) Dorchester Co Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country)

14 Informant: Ellen Glover

(Address) 1034 Vine St.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26/27 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 19 27 to Oct 26 19 27, that I last saw h... alive on Oct 26 19 27, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) _____, M. D.

, 19 (Address) _____

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial Oct 29 19 27

20 UNDERTAKER: Sam'l J. Chase — ADDRESS 1730 Madison

OF DEATH in plain terms, so that it may be properly classified. FACT STATEMENT OF OCCUPATION IS very important. See instructions on back of certificate.

C. HAMPSON JONES, M. D.

OCT 28 1927 P.M.

Spec. 6-9-19—H. P. Co.—1000 Bks.

16-002

E 26914 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26914

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 808 S. Exeter St. (Ward) 26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harman Carroll Brodsky

(a) RESIDENCE. NO. 808 S. Exeter St. (Ward) 26

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 15, 1926

7 AGE: Years 1 Months 1 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (City or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Herbert Brodsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Eddie Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Herbert Brodsky 808 S. Exeter St.

15 Filed OCT 29 1927 Registrar HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27 '27

17 I HEREBY CERTIFY, That I attended deceased from Oct 27 '27, to Oct 27 '27, that I last saw him alive on Oct 27 '27, and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Acute Entero Colitis

(duration) — yrs. — mos. 24 hrs.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Leonard M. D.

282 (Address) 820 E. Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct. 29th 1927

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 403 S. Broadway

D.

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

E 26915 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH So. Balto Resi Hosp. 118-00

City of BALTIMORE: (No. 1211-1213 Light St. 25-75 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin Swinton

(a) RESIDENCE NO. 103 Second Ave Brooklyn Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 3 mos. 2 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24, 1906

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	21	3	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Car cleaner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Swinton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emma Trevis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Joseph Swinton
(Address) 103—2nd Ave Brooklyn Md

15 OCT 29 1927 HAMPSON JONES, M. D. Address

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 10-23, 1927, to 10-26, 1927, that I last saw h.... alive on 10-26, 1927, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Gen. peritonitis
(duration) yrs. mos. 2 ds.

18 Where was disease contracted
If not at place of death!
Did an operation precede death! Yes Date of 10 25 27
Was there an autopsy? No
What test confirmed diagnosis? E. Pleasants
(Signed) E. Pleasants, M. D.
, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Leader Gilbert Oct 29 19

20 UNDERTAKER — ADDRESS
C. Howard Evans 38 E. Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

William Anderson

E 26916

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26916

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 Preston St. 11-24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Anderson

(a) RESIDENCE NO. 309 Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Anderson

6 DATE OF BIRTH (month, day, and year): Dec. 24. 1877

7 AGE: Years 30 | Months 9 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ref Press Man

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: Sun Lithograph. Co.

9 BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10 NAME OF FATHER: Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn.

12 MAIDEN NAME OF MOTHER: Mary McCue

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn.

14 Informant: Fannie McCue

(Address): 309 Preston St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 26th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18th, 1927, to Oct. 26th 1927, that I last saw h[illegible] alive on Oct 22nd 1927, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Ref Pressman

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) X. [illegible] M. D.

(Address) 92 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. | DATE OF BURIAL: Oct 29 1927

20 UNDERTAKER: Samuel Hensley | ADDRESS 518 W Baltimore

OCT 29 1927 HARRISON BROS

Dr.

FION IS very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 26917

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26917

CERTIFICATE OF DEATH

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1108 - 6 E Pr St., 75-75 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morrell Pr Margaret R. Pr Allick

(a) RESIDENCE NO. 1108 - 6 E Pr St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year) Aug 28th 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or....min.
	—	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto -

PARENTS

10 NAME OF FATHER Auty Allick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Carrie Dantonio

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Auty Allick

(Address) 1108 E 6th -

15 Filed ... 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry), thereon and from the evidence obtained by the Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

Oct 28 1927 (Address) Curtis Bay, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent Cmty Date of Burial Oct 29 1927

20 UNDERTAKER Wm Cook ADDRESS 552 E Pratt St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Blks.

E 26918

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 26918

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY H[illegible] St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Sears

(a) RESIDENCE NO. 1302 Dillman St. Ward

(Usual place of abode) 11 years

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Sears

6 DATE OF BIRTH (month, day, and year) ? 1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Geo. Sears

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Amanda ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records.

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/28/1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1927, to Oct. 28, 1927

that I last saw him alive on Oct. 28, 1927.

and that death occurred, on the data stated above, at 7:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

Cerebral Sclerosis

(duration) yrs. 3 mos da.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos da.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? General Exam.

(Signed) C. Julius Segal M. D.

, 19 (Address) CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Total Grove	10/ , 192[illegible]
20 UNDERTAKER	ADDRESS
J. M. Cook	1126 North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26919

HEALTH DEPARTMENT—CITY OF BALTIMORE

128 E 26919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary REGISTERED NO. 23-37

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Donahue

(a) RESIDENCE NO. 1717 E Chase St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie M Donahue

6 DATE OF BIRTH (month, day, and year): May 9, 1874

7 AGE — Years: 53 — Months: 7 — Days: 16 — If LESS than 1 day, hrs or min.: 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist 081

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B&O R.R.

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Thomas Donahue

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Annie Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Carrie Donahue

(Address): 1717 E Chase St

15 Filed ..... 19 .....

OCT 29 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1927, to Oct 27, 1927, that I last saw him alive on Oct. 27, 1927 and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos 6 hours ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood chem. etc

(Signed) Jr Frank Hewitt, M. D.

, 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 31 19 27

20 UNDERTAKER: Wilson Lock — ADDRESS: 2018 York Ave City

Spec.—1-12-23—M&T—500 Bks.

E 26920

189767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9-18 ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME SARAH K. BISSON

(a) RESIDENCE No. 113 East North Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nathan Bisson

6 DATE OF BIRTH (month, day, and year): May 21, 1852

7 AGE: Years 75 Months 5 Days 8

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Durham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address)

15 Filed OCT 29 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1926, to Oct. 28, 1927, that I last saw her alive on Oct. 28, 1927, and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (right) with left paralysis (hemiplegia), arteriosclerosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis of heart (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Ruth E. Fairbanks, M. D.

10/28, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 10/31 1927

20 UNDERTAKER: J. W. Cook

ADDRESS: 502 Gilmor

TION is very important. See instructions on back of certificates.

Special Form No.—200 Bks.

E 26921

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26921

CERTIFICATE OF DEATH

47

REGISTERED NO.

I-PLACE OF DEATH

City of BALTIMORE: (No. 3008 Fendall Ave 28-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Violet Fluegel James

(a) RESIDENCE NO. 3008 Fendall Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Bernard C. James

6 DATE OF BIRTH (month, day, and year) Oct 7 1881

7 AGE	Years	Months	Days
	46	—	15

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Erie Pa

(State or country)

PARENTS

10 NAME OF FATHER Maurice Fluegel

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Emma Loeb

13 BIRTHPLACE OF MOTHER (city or town) Nunda

(State or country) N.Y.

14 Informant Bernard C. James

(Address) 3008 Fendall Ave

15 Filed OCT 29 1927 19 C. HAMILTON JONES PM

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 9 1925 to October 27 1927, that I last saw her alive on October 26 1927, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Metastasis to the bones of spine & pelvic girdle

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 9 1925

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam of Primary growth - X Ray Exam of growth

(Signed) Louis P. Hamburger M. D.

Oct 28 1927 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dust Hebrew Cemetery

Date of Burial Oct 30 1927 19

20 UNDERTAKER J. Emanuel & Sons

ADDRESS 2432 Pennsylvania Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 26922 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26922

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 Arlington Ave ST. 18-N WARD)

2-FULL NAME Elizabeth Green Robinson

(a) RESIDENCE NO. 312 N. Arlington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Robinson

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE — Years: 77 — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~Laundry Employee~~ Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Virginia

PARENTS

10 NAME OF FATHER: Thomas Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Virginia

12 MAIDEN NAME OF MOTHER: ~

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Virginia

14 Informant: Florence Walters, Niece

(Address): 312 Arlington Ave

15 Filed OCT 29 1927 — H. HARPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-8, 1927, to 10-28, 1927, that I last saw her alive on 10-27-, 1927, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

myocarditis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary): nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & symptoms

(Signed) John C. C. Lamper, M. D.

, 19 (Address) 1905 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Oct 31 1927

20 UNDERTAKER: Mrs Katie R. Williams — ADDRESS 922 N. Schroeder

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

TION is very important

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26923

CERTIFICATE OF DEATH.

117 E 26923

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 6-11 Ward)

2-FULL NAME Leon C. Morrow

(a) RESIDENCE NO. 146 N. Ellwood Ave St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nellie I. Morrow

6 DATE OF BIRTH (month, day, and year) July 19-1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Henry Morrow

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Ruth Grant

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Va

14 Informant Nellie I. Morrow

(Address) 146 N. Ellwood Ave

15 Filed _____ 19 _____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27-1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Allen M. D.
(Coroner)

19 10/27/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.. mos., ds. In the State..... yrs.. mos.. ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Oct 31 1927

20 UNDERTAKER George J. Smith Hollins ADDRESS 153 L

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 26924

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26924

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 4323 Walnut Ave St. 98-66 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Wright Hammond

(a) RESIDENCE NO. 4323 Walnut Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: W Ridgely Hammond

6 DATE OF BIRTH (month, day, and year): June 4 1861

7 AGE: Years 46 Months 4 Days 24 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Queen Annes Co. (State or country) Md

PARENTS

10 NAME OF FATHER Stephen L Wright

11 BIRTHPLACE OF FATHER (City or town) (State or country) Queen Annes Co Md

12 MAIDEN NAME OF MOTHER Laura Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queen Annes Co Md

14 Informant W R. Hammond

(Address) 4323 Walnut Ave

15 Filed OCT 29 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28th 1927

17 I HEREBY CERTIFY, That I attended deceased from January 1927 to Oct 28th 1927, that I last saw h[illegible] alive on Oct 28th 1927, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma of Liver secondary to Carcinoma of Breast, record January 1927.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of January 1927.

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Howard Kelly M. D.

10/28, 1927 (Address) 711 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Oct 31 1927

20 UNDERTAKER: George J Smith — ADDRESS: 1532 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 26925 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Fulton Ave & Franklin St

CITY OF BALTIMORE: (No.) Methodist Aged Home (St.) 9-27 (Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Baltman

(a) RESIDENCE. No. Fulton Ave & Franklin St Aged Home St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 3, 1855

7 AGE — Years: 72 Months: 7 Days: 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William A. McCreary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carl Co. Md

12 MAIDEN NAME OF MOTHER: Martha Scaff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cayd Co Md

14 Informant: Ella Cuddy (Address) 420 N Fulton Ave

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1925 to Oct 27 1927

that I last saw her alive on Oct 27 1927

and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Paralysis Agitans

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Cardiac Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) George L. Wiseman, M. D.

19... (Address) 4200 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: Oct 31 1927

20 UNDERTAKER: George J. Smith — ADDRESS: 1532 Hollins

SEP 29 1927 C. HAMPSON JONES, M.D.

Spec.—1-12-23—M&T—500 Bks.

E 26926 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26926

CERTIFICATE OF DEATH. 74-602

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (NO. 1 Balto Md ST. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodosia Perry

(a) RESIDENCE NO. 615 Mulberry St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Unknown Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Uncertain 851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 70

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Balto City Hospt Balto Md

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/27

17

I HEREBY CERTIFY, That I attended deceased from 11/12/26 to 10/27/27, that I last saw h[illegible] alive on 10/26/27, 19 and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

Terminal Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Sclerosis of Cerebral Arteries Pelvis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) John F. Dreisbach M. D.

10/27/1927 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary DATE OF BURIAL Oct. 30, 1927

20 UNDERTAKER Mrs. A. G. Elliott ADDRESS 1725 Ashland Ave

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 26927

207 8 97

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 6-4 101

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME GERALDINE COPELAND

(a) RESIDENCE No. 1012 Durham ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~: Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 1927

7 AGE: Years: 6 months | Months: " | Days: 1 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Willie COPELAND

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER CORA BASMORE

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 26 , 1927, to Oct 27 , 1927, that I last saw her alive on Oct 27 , 1927, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos 21 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Allan Blayney, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem. | DATE OF BURIAL: Oct. 29 27

20 UNDERTAKER: Mrs. R. G. Elliott | ADDRESS: 1119 Ashland Ave

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26928

90 E 26928

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 15-N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dietz

(a) RESIDENCE NO. 2018 Hadbrook St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: 65 Years Months Days

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (City or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-28 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-7, 1927, to 10-28, 1927, that I last saw him alive on 10-28, 1927, and that death occurred, on the date stated above, at 10 20 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Infectious arthritis

Arterio sclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) C. Holmes Jones M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — Date of Burial: Oct 29 1927

20 UNDERTAKER: Geo W Little — ADDRESS 2700 Edmondson Ave

OCT 29 1927 C. HAMILTON JONES, M. D. Registrar

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 26929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 26929

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 719 School St. 14-20 Ward)

2-FULL NAME Ada Anna Carter

(a) RESIDENCE NO. 719 School St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 31 1927

7 AGE: Years 1 Months Days 25 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: Harry Carter

11 BIRTHPLACE OF FATHER (city or town): Balto
(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Jones

13 BIRTHPLACE OF MOTHER (city or town): Pittsburg
(State or country): Pa.

14 Informant: Mary Carter
(Address): 719 School St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 14 1927, to Oct 27, 1927, that I last saw h[illegible] alive on Oct 27, 1927, and that death occurred, on the date stated above, at 9.20 p. m.

The CAUSE OF DEATH* was as follows:
Acute Ileo Colitis

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted (duration) ..... yrs. ..... mos. 2 ds.
If not at place of death!
Did an operation precede death! ..... Date of .....
Was there an autopsy!
What test confirmed diagnosis!

(Signed) E William Test, M. D.
10/27/1927 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial Oct 29 1927

20 UNDERTAKER: Chas. H. Johnson ADDRESS 416 N. Carolina

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

E 26930

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00

E 26930

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Gen Hospital (Hospital) (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Savitzky Jr

(a) RESIDENCE NO. 114 Albemarle ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Savitzky

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE — Years: 53 — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

14 Informant (Address): Anna Savitzky 1511 N Pratt St.

15 Filed OCT 29 1927 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1927, to Oct 27, 1927, that I last saw him alive on Oct 27, 1927, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): myocardial insufficiency (duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Morris D. Cohen, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 10/31 19 27

20 UNDERTAKER: Chas H Zuchowski — ADDRESS: 637 S Paca St.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26931

CERTIFICATE OF DEATH.

X 129 E 26931

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital 1648

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T Windley

(a) RESIDENCE NO. Belchaven, N. C. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Windley

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years: about 56; Months; Days; If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Waterville, N.C.

PARENTS

10 NAME OF FATHER: Wm. B. Windley

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Minerva Topping

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant: Hospital Records

(Address): West Balto General Hosp

15 Filed Oct 29 1927 C H G Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1927, to Oct 29, 1927

that I last saw him alive on Oct 29, 1927

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Uremia Coma

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) mos. ds.

Auricular Fibrillation

Chronic Myocarditis

18 Where was disease contracted (if not at place of death?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam

(Signed) Louis T. Lavy, M. D.

1927 (Address) W. Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Waterville N.C.

DATE OF BURIAL: Oct 29" 1927

20 UNDERTAKER: Coe & B Cook

ADDRESS: 603 N. Calvert St

TION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 26932

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26932

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 172 S. Division St., 14-20 Ward) 129

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel W. Barnes

(a) Residence No. 172 S. Division St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Edith J. Barnes

6-DATE OF BIRTH (month, day and year) May 11th 1862

7-AGE. 65

66 yrs. 5 mos. 19 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Waiter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Charles Thibling

9-BIRTHPLACE (city or town) Harford County (State or Country), Maryland

PARENTS:

10-NAME OF FATHER, Charles W. Barnes

11-BIRTHPLACE OF FATHER (city or town) Harford Co (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Hester Hamilton

13-BIRTHPLACE OF MOTHER (city or town) Harford Co (State or Country), Maryland

14- (Informant) Edith J. Barnes

(Address) 172 S. Division St

15-

Filed ..... 1927 ..... Registrar.

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 20 / 27

17- I HEREBY CERTIFY, That I attended deceased from April 16 1927, to October 20 1927, that I last saw h. alive on October 26 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary metastasis

(Duration) yrs. 11 mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No Urinalysis & sputum

What test confirmed diagnosis? Clinical findings

(Signed) Burwell Lang M. D.

, 19 (Address) 2937 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Harford Co Md Fair Mountain Cem

DATE OF BURIAL, 10-30 1927

20-UNDERTAKER, Samuel Brunk

ADDRESS 778 N Eden

Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 26933

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 23 N Broadway (St.) 6-4 (WARD)

2-FULL NAME Rose Brownstein

(a) RESIDENCE No. 23 N Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/11/1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	27	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Myer Brownstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Freda Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Nathan Brownstein
(Address) 431 N Broadway.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29, 1927

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1927, to Oct 29, 1927, that I last saw h. alive on Oct 28, 1927 and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? None

(Signed) R. L. Cochran M. D.

10/29 19 (Address) 1514 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Oct 30 1927
20 UNDERTAKER J Kennon Bro	ADDRESS 1127 E Balto St

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 26934

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26934

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD) 47-52

2-FULL NAME Walter Allen

(a) RESIDENCE NO. 831 Powers St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 4 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Allen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Ruth M. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Hospital Records.

15 Filed 30 1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29-27 19

17 I HEREBY CERTIFY, That I attended deceased from 10-28-27, 19, to 10-29-27, 19,

that I last saw h alive on 10-29-27, 19

and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

General Peritonitis subsequent to Ruptured Gangrenous Appendix

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Terminal Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? None.

Did an operation precede death? Yes Date of 10-28-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Neil M. Hall, M. D.

, 19 (Address) Franklin Square Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL Nov 1 27

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Fallsway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 26935

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Albaugh

(a) RESIDENCE NO. 13 Fr Arguello St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of: Minnie Albaugh

6 DATE OF BIRTH (month, day, and year): Mar 4 1864

7 AGE: Years 63 Months 7 Days 24

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stage Hand

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D C

(State or country)

PARENTS

10 NAME OF FATHER Henry Albaugh

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Denny

13 BIRTHPLACE OF MOTHER (city or town) Del

(State or country)

14 Informant Mrs. Eaton

(Address) 506 Oakland Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28, 19 27

17 I HEREBY CERTIFY, That I attended deceased from 9-1-, 19 27 to 10-28, 19 27

that I last saw him alive on 10-28, 19 27

and that death occurred, on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia & Empyema

(duration) two weeks

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-2-27

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Report

(Signed) Sylvester, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Oct 31 1927

20 UNDERTAKER W S Marshall ADDRESS 2539 Fall Rd

OCT 31 1927 C. HARPSTER

OCT

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26936 E 26936

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 954 Harford ST. 11 1 WARD)

2-FULL NAME Mary Ellen Kelly

(a) RESIDENCE NO. 954 Harford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Patrick J. Kelly.

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE Years 68 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Patrick Colford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Joseph Kelly Son (Address) 954 Harford Ave

15 Filed OCT 31 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 28, 1927 that I last saw h alive on Oct 28, 1927 and that death occurred, on the date stated above, at 3.05 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) W. Clyde Fisher, M. D.

Oct 29, 1927 (Address) 2017 E. 32nd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Oct 31 1927

20 UNDERTAKER Edward W. Conklin ADDRESS 2446 E. Monument

TION is very important - See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26937

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26937

CERTIFICATE OF DEATH.

1927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 Linden Ave St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Dallam Block

(a) RESIDENCE NO. 1507 Linden Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 94 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Block

6 DATE OF BIRTH (month, day, and year): Nov 25 1832

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
94	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Samuel Dallam

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Catherine Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Emily D. Chesshire

(Address) 2345 Broadway Apt 2

15 Filed ..... 1927 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1927, to Oct. 28, 1927, that I last saw h alive on Oct. 28, 1927 and that death occurred, on the date stated above, at 7 P. m

The CAUSE OF DEATH* was as follows:

Heat Exhaustion

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary): old age,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hunt Townsend M. D.

, 19 (Address) 3524 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. — DATE OF BURIAL: Oct 31 1927

20 UNDERTAKER: Wm Fickus Sons — ADDRESS: North Ave

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26938

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26938

CERTIFICATE OF DEATH.

88

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Wilkens Ave ST. WARD) REGISTERED NO. 20-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Genevieve Hessenauer O'Bannion

(a) RESIDENCE No. 2232 Wilkens Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18, 1905

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
22	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S.F.&G. Co

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Hessenauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Estelle Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

11 Informant Mrs. Estelle O'Bannion

(Address) 2232 Wilkens Ave.

15 Filed Oct 29, 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to Oct 28, 1927, that I last saw h[illegible] alive on Oct 28, 1927, and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis (streptococcus viridans) Embolism of Brain.

CONTRIBUTORY (Secondary) Pulmonary edema. (duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 1 ds. Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Norman C Peterson M. D.

Oct 29, 1927 (Address) 2151 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem DATE OF BURIAL: Oct 31 1927

20 UNDERTAKER: W M Fuchs Sons ADDRESS: North & Pa

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26939

E 26939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Northway ST. Guilford WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Parish Hood

(a) RESIDENCE No. 18 Northway ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER M. Bowman Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mabel V. Joyner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Dr. M. Bowman Hood

(Address) 18 Northway

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1927, to Oct. 27, 1927, that I last saw her alive on Oct 27, 1927, and that death occurred, on the date stated above, at 1 P m

The CAUSE OF DEATH* was as follows:

Chronic Suppurative Bronchiectasis (Lung Abscess)

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1923

Was there an autopsy? No Lung Abscess

What test confirmed diagnosis? Xray + Operation

(Signed) J. A. C. Longfellow, M. D.

Oct 28 1927 (Address) 818 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Oct 31 1927

20 UNDERTAKER Wm Tretter Sons ADDRESS North Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26940

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3639 Reisterstown Rd St. WARD) 15-58

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson D. Kenzie

(a) RESIDENCE NO. 3639 Reisterstown Rd St.

(Usual place of abode)

WARD Retired Wis

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fannie E. Kenzie

6 DATE OF BIRTH (month, day, and year) June 20-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	83	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jack Dror Dealer

9 BIRTHPLACE (city or town) Michigan
(State or country)

PARENTS

10 NAME OF FATHER W. Kenzie

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs S. E. Wilson
(Address) 3639 Reisterstown Rd

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1927, to Oct 29, 1927,
that I last saw h.. alive on Oct 28, 1927
and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Cardio Nephritis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. H. Ryan, M. D.

Oct 30, 1927 (Address) 500 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Beloit, Wis

DATE OF BURIAL Oct 31 1927

20 UNDERTAKER Wm J Jackson. Sons

ADDRESS Fort Pa Ave

TION is very important See instructions on back of certificates.

30 1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 26941

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26941

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Wyman Park Apartments ST. 12-48 WARD) 83

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Parker

(a) RESIDENCE No. Wyman Park Apartments ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
M.	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily L Parker

6 DATE OF BIRTH (month, day, and year) Oct 1-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	83	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charleston S.C.

PARENTS

10 NAME OF FATHER Hugh L. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Maria Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Edgetown Me

14 Informant Edward L Parker (Address) Wyman Park Apts

15 Filed . . . . , 19 . . . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29th 1927

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1926, to October 29, 1927.

That I last saw him alive on October 28, 1927,

and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Some yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral softening

(duration) 1 yr. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) George M Gribb M. D.

10/29 1927 (Address) 4435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemt

DATE OF BURIAL Oct 31st 27

20 UNDERTAKER Fortune & Son

ADDRESS 1723 W Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T. HAMPSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26942

CERTIFICATE OF DEATH.

186-003 E 26942

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp. St. 15-58 Ward)

2-FULL NAME Howard H. League

(a) RESIDENCE NO. 4102 Reisterstown Rd. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth League

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Martin League

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Louisa E Duckett

(Address) 4102 Reisterstown Rd

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull almost instant death

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

(Address) 2572 Edmondson Ave

Oct. 28 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cem. Date of Burial Oct 31 1927

20 UNDERTAKER Nelson Cook ADDRESS 502 Mosher

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 26943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 26943

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 27-48 WARD)

2-FULL NAME Chas. Roy Chalk

(a) RESIDENCE NO. Kirkley Rd. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3. 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		1	8 wks 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Killen Rd Md.

PARENTS

10 NAME OF FATHER Wm M. Chalk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Cahlenhurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mother
(Address) 5210 Belleona Ave.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1927, to Oct 28, 1927, that I last saw him alive on Oct 28, 1927 and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H J Geraghty M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 10/31 1927

20 UNDERTAKER Wm Cook — ADDRESS 502 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important See instructions on back of certificates.

OCT 29 1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

Dr E A Retzel 2227 Fulton Ave

E 26944

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 26944

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

*1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2804 Woodbrook Ave ST. 43-59 WARD

2-FULL NAME Agnes C. Craig

(a) RESIDENCE NO. 2804 Woodbrook Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas N. Craig

6 DATE OF BIRTH (month, day, and year) Jan 20 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER C. B. Schafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Rothust

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Agnes E. Mitford 2804 Woodbrook Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1927

17

I HEREBY CERTIFY, That I attended ~~deceased~~ from October 19th, 1927, to Oct. 28th, 1927, that I last saw her alive on Oct. 28th, 1927, and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Albert C. Reisert, M. D.

, 19 (Address) 2227 N. Fulton Ave. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Md — DATE OF BURIAL Oct 31 1927

20 UNDERTAKER William Cook — ADDRESS 502 E North

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. THOMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26945

CERTIFICATE OF DEATH

160 E 26945

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 176 W. Fort Ave St. 24-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll L. Smith

(a) RESIDENCE NO. 176 W. Fort Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 17 1927

7 AGE: Years 1 Months Days 17 IF LESS than 1 day ..... hrs. or ..... min.. 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (City or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Agnes E. Hilson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Chas. Smith

(Address) 176 W. Fort Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/29/27

17 I HEREBY CERTIFY, That I attended deceased from 10/24/27, 19..... to 10/29/27, 19.....

that I last saw him alive on 10/28/27, 19.....

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

Enteritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ex Lambert

(duration) yrs. mos. ds.

18 Where was disease contracted ?

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. C. Hamilton, M. D.

(Address) 1419 W. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: Oct 31 1927

20 UNDERTAKER: Margaret J. Flynn — ADDRESS: 1421 Light St.

tion should be carefully applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-002

E 26946

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St Joseph's Hospital St. 24-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Knox

(a) RESIDENCE NO. 1309 Hull St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Abt. 1870

7 AGE — Years: 57 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: John Knox

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Buckley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Potts

(Address): 1309 Hull St.

15 Filed ..... 19 .....

OCT 30 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29- 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1927, to Oct 29, 1927, that I last saw h[illegible] alive on Oct 29, 1927, and that death occurred, on the date stated above, at 4.25 P m.

The CAUSE OF DEATH* was as follows:

Emphysema.

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Myocarditis + Toxemia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 27-1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: Oct 31 1927

20 UNDERTAKER: Margaret J. Flynn — ADDRESS: 1417 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 26947

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Joseph's Hospital St. (Ward) 35

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Akehurst

(a) RESIDENCE NO. 1406 Towson St. St. Ward Baltimore Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. E. Akehurst

6 DATE OF BIRTH (month, day, and year): Mar. 23, 1877

7 AGE — Years: 50 Months: 7 Days: 3 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer:

9 BIRTHPLACE (city or town): England

(State or country)

PARENTS

10 NAME OF FATHER: Patrick Ellis

11 BIRTHPLACE OF FATHER (City or town): England

(State or country)

12 MAIDEN NAME OF MOTHER: Ann Fudge

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Wm E. Akehurst

(Address) 1406 Towson St.

15 Filed ..... 19 .....

Registrar

RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct 28 – 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1927, to Oct 28, 1927

that I last saw h[illegible] alive on Oct 28, 1927

and that death occurred, on the date stated above, at 8.05 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of Oct 10 – 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. J. Thompson, M. D.

Oct 28 19 27 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: Oct 31, 19 27

20 UNDERTAKER: Margaret J. Flynn — ADDRESS: 1421 Light St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26948

CERTIFICATE OF DEATH.

129 E 26948

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N Central Ave ST. 10-14 WARD)

2-FULL NAME Oliver Jones

(a) RESIDENCE NO. 711 N Central Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Widowed

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Alice Jones

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber wagon

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Joshua Jones (son) 1426 E Madison st

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 4, 1927, to Oct 28, 1927,

that I last saw h alive on Oct 27, 1927,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? ~~Yes~~ No

What test confirmed diagnosis? Physical

(Signed) T J Yoe M. D.

10/24 1927 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Oct 31 1927

20 UNDERTAKER Chas. H. Johnson ADDRESS 467 N. Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001
E 26949
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Garfinkel

(a) RESIDENCE NO. 2318 E Fairmont St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	wd.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE 65 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant
(Address)

15 Filed 31 1927 19 RKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-28, 1927, to 10-29, 1927, that I last saw her alive on 10-29, 1927 and that death occurred, on the date stated above, at 11 20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, left.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertention

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Phys. Examination

(Signed) C. Holmes Boyd, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cedar Hill 10-30 1927

20 UNDERTAKER ADDRESS

Jack Levin, 1429 E. Balto.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 26950

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount St. 95 W. WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. John F. Towson

(a) RESIDENCE NO. 85 W. 37th ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Towson

6 DATE OF BIRTH (month, day, and year) Nov. 21-1858

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery clerk

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Edw. Towson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Walker

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md. Maryland

14 Informant Mrs. J. F. Towson
(Address) 85 W. Edmondson Ave

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1927, to Oct 29, 1927, that I last saw him alive on Oct. 29, 1927 and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia - Hypostatic

Pneumonia (duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood chemistry, Urine examination, Physical examination

(Signed) J. Francis Reese M. D.

Oct 31 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Nov. 1- 1927

20 UNDERTAKER Horace F. Burgee ADDRESS 4411 Falls Rd

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

VYRAH E 26951

CERTIFICATE OF DEATH.

100-91 26951

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Maryland Gen. Hosp. (St., or WARD) 59

2-FULL NAME Tyrah Catherine Marr

(a) RESIDENCE NO. 1510 Kenseth Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 29-1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Leo Marr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ruth M. Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Andrew Leo Marr

(Address) 1510 Kenseth Ave.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27- 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1927, to Oct 27, 1927, that I last saw her alive on Oct 27, 1927, and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

(Address) [signature]

, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct. 31 1927

20 UNDERTAKER Horace F. Burgee

ADDRESS 3631 Gallows Rd.

Spec.—7-17-26—A Co.—200 Bks.

E 26952

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 51 E 26952

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital (St.) 4 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Chambers

(a) RESIDENCE NO. Ellicott city (St.) Md Ward

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1924

7 AGE — Years: 3 — Months: — — Days: — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co Md

(State or country)

PARENTS

10 NAME OF FATHER Alfred Chambers

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lula Dole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Alfred Chambers Ellicott City Md

15 Filed — —, 19— — M. Registrar NRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 10-30-27

17 I HEREBY CERTIFY, That I attended deceased from 10-26-27, 19 , to 10-30-27, 19 , that I last saw h alive on 10-30-27, 19 , and that death occurred, on the date stated above, at 12 45 a.m.

The CAUSE OF DEATH* was as follows:

I Pneumatic Endocarditis

(duration) yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Ira Johnston M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stephens Cem Ellicott City Md. Date of Burial Dec 31 1927

20 UNDERTAKER: Scott M. Shaw ADDRESS: Ellicott City Md

DEC 30 1927 C. HAMPSON JONES, M. D.

(Should be carefully supplied. ALL PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.—1-10-23—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26953

CERTIFICATE OF DEATH.

31 E 26953

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1244 E. Monument ST. 10-14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jones

(a) RESIDENCE NO. 1244 E. Monument ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	colrd	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anne Jones

6 DATE OF BIRTH (month, day, and year) Dec 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md - C.

PARENTS

10 NAME OF FATHER Thos Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy — 10/27 1927

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anne Jones
(Address) 1244 E. Monument

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1927, to Oct 25, 1927.
that I last saw h[illegible] alive on Oct 25, 1927.
and that death occurred, on the date stated above, at 4 30 p.m.
The CAUSE OF DEATH* was as follows:

Ch Pulmonary Th.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. H. Hovermale M. D.

10/27, 1927 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Oct 31 1927

20 UNDERTAKER John H. Toadvine — ADDRESS 10 27 Druid Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 31 1927 H[illegible] M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

183 ✓ E 26954

1 PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St. 13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. Comley

(a) RESIDENCE NO. 1202 Hanover St. 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Mary E. Comley

6 DATE OF BIRTH (month, day, and year): 6/24/05

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	12	4	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Plaster
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: George Comley

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Phoebe Arrington

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Balto Co Md

14 Informant: Mary E Comley
(Address): 1232 Hanover st

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy and inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:
Gun Shot Wound
Left Groin
Accidental
(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (secondary)
(duration) .....yrs. .....mos. .....ds.

(Signed) Jay Morrison M. D.
(Coroner)

10/30 1927 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestnut Ridge Carroll Chapel — Date of Burial: 11/1 1927

20 UNDERTAKER: Williams Cook — ADDRESS: 502 E Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Dr Rozanek - 801 N Kenwood Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26955

CERTIFICATE OF DEATH.

74-61

E 26955

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Lakewood Ave ST. 1-3 WARD)

2-FULL NAME Edward Rozel

(a) RESIDENCE NO. 602 S. Lakewood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Minnie Rozel

6 DATE OF BIRTH (month, day, and year) Oct 13, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Dublin Ireland

PARENTS

10 NAME OF FATHER John Rozel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo Rozel
(Address) 2025 E. Fairmount Ave

15 Filed Oct 31, 1927 H. Page Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1927 to Oct 28, 1927

that I last saw him alive on Oct 28, 1927

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Rozanek, M. D.

(Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 10/31 1927

20 UNDERTAKER — ADDRESS 827 E Lombard St

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

48 V

E 26956

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hospital St. 15 Ward 64)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ella M Larkin

(a) RESIDENCE NO. 3115 Liberty Heights St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. E. Larkin

6 DATE OF BIRTH (month, day, and year): Nov 20, 1865

7 AGE: Years 61 Months 11 Days 10 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town): Frederick Md

(State or country)

PARENTS

10 NAME OF FATHER: Jos Julian

11 BIRTHPLACE OF FATHER (City or town): Frederick, Md

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Lauz

13 BIRTHPLACE OF MOTHER (city or town): Frederick Md

(State or country)

14 Informant: Hospital Records

(Address)

15 Filed ..... 19 ..... RUK. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 10/13, 19 27, to 10-24, 19 27,

that I last saw h alive on 10/30, 19 27,

and that death occurred, on the date stated above, at 12:15 a m.

The CAUSE OF DEATH* was as follows: Cerebral Embolism of Heart

Duration

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted: Home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Jno A Anderson M.D.

, 19 (Address) 1 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet, Frederick, Md

Date of Burial 11/2 19 27

20 UNDERTAKER: J. F. Cook

ADDRESS 502 E Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

E 26957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 26957

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1432 Holbrook St. 9-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvina Zehntner

(a) RESIDENCE NO. 1432 Holbrook St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S. if of foreign birth? 50 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Frank Zehntner

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: Years: about 70 Months: — Days: — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: William Steinbach

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town): Not known

(State or country)

14 Informant: Mr. Frank Zehntner

(Address) 1432 Holbrook St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 30 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 19 27, to Oct 30, 19 27, that I last saw h[illegible] alive on Oct 30th, 19 27, and that death occurred, on the date stated above, at 2:15 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 16 ds.

CONTRIBUTORY (Secondary): Coma

(duration) — yrs. — mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. B. Cook M. D.

(Address) 1501 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: Nov 1 1927

20 UNDERTAKER: Henry Hock Son — ADDRESS: 1301 E Eutaw St

FILED NOV 1 1927 Per C. HAMPSON JONES M. D. Registrar

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26958

CERTIFICATE OF DEATH.

Mt Washington

160 E 26958

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 32 Mattfeldt Ave ST. 27-5th WARD)

2-FULL NAME Marion L. Starman

(a) RESIDENCE NO. 32 Mattfeldt Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16-1927

7 AGE	Years	Months	Days	If LESS than 1 day, brs or min
	0	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Reuben L. Starman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Mercie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co

14 Informant Reuben L. Starman
(Address) 32 Mattfeldt Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30th 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1927, to Oct 30th, 1927, that I last saw her alive on Oct 29th, 1927, and that death occurred, on the date stated above, at 11.00 A m.

The CAUSE OF DEATH* was as follows:

Cachexia
(inability to assimilate food.)

(duration) yrs. mos 40 ds.

CONTRIBUTORY (Secondary) Born a twin very weak & small.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Oct 30/1927 (Address) 846 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge C. DATE OF BURIAL Oct 31 1927

20 UNDERTAKER A. J. Marshall ADDRESS 3339 Telford

Spec.—12-9-25—A Co—200 Blks.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

CERTIFICATE OF DEATH.

E 26959

E 26959

1-PLACE OF DEATH

City of BALTIMORE: (No. 3932 Lowndes ave 9 Ward) 9-47

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Virginia Dames

(a) RESIDENCE NO. 3932 Lowndes ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) about March 15— 1852 (?)

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
75	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Dames

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto - md

12 MAIDEN NAME OF MOTHER Christina Hauer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Co., Md.

14 Informant Mrs. Louis N. Sinclair

(Address) 3932 Lowndes ave

15 Filed....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 30, 1927.

17

I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1927, to Oct. 30, 1927, that I last saw h.. alive on Oct. 29, 1927, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Do not know

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Refused.

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Maurice E. Shamer, M. D.

(Address) 3300 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

H Mayo Graves. 11/2/27.

20 UNDERTAKER — ADDRESS

J. J. Fahey & Sons 1818 Eutaw St.

GIVE AGE CORRECTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

26960 E

38 ✓

REGISTERED NO. E 26960

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Brown

(Residence)

(a) RESIDENCE NO. Ridgely St. Ext, Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Husband of Lizzie Brown

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 67 Months Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED:
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O&O
(c) Name of employer

9 BIRTHPLACE (city or town): New York City
(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): unk
(State or country)

12 MAIDEN NAME OF MOTHER: unk

13 BIRTHPLACE OF MOTHER (city or town): unk
(State or country)

14 Informant: Mrs Lizzie Brown
(Address) Rear 4 Ridgely St Ext.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/27 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/27 1927, to 10/27 1927,
that I last saw h[illegible] alive on 10/27 1927,
and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:
Tuberculosis Aortity & Concussion
Secondary Tracheal
obstruction
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Pulmonary oedema
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death? Unknown
Did an operation precede death? No Date of .....
Was there an autopsy? yes
What test confirmed diagnosis? clinical and X ray & P.M.

(Signed) F L Lindsay, M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park	10/31, 1927
20 UNDERTAKER: J J Fahey & Sons	ADDRESS: 1318 Light

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 31 1927 [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26961

CERTIFICATE OF DEATH.

E 26961

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 572 E. North Ave ST., 9-W WARD)

2-FULL NAME baby Mason

(a) RESIDENCE No. 572 E. North ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
X	X	X	7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs Edna Mason

(Address) 572 E. North Ave

15 Filed ... 19... Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 29 1927 19

17

I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19...

that I last saw h... alive on ... 19...

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth (probably edema of lungs)

7 hours (duration)

CONTRIBUTORY (Secondary) Premature birth

(duration) ... yrs. X mos. X ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical evidence

(Signed) Otto H. Duker M. D.

... 19... (Address) 928 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Oct 31 1927

20 UNDERTAKER: Chas. E. Branch — ADDRESS: 802 Madison Ave

BEFORE SIGNING BE CAREFUL, SUPPLIED. ASCERTAIN THE FACTS AND SEE THAT ALL ITEMS ARE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26962

CERTIFICATE OF DEATH.

113E 26962

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 600 N. Charles St. (Ward) 11-25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Edwards

(a) RESIDENCE. No. 600 N. Charles St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 19, 1927

7 AGE — Years — Months — Days 10

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James C Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Helen Hanes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant James C Edwards
(Address) 600 N Charles St.

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/19, 1927, to 10/29, 1927, that I last saw him alive on 10 29, 1927, and that death occurred, on the date stated above, at 11 20 A. m.

The CAUSE OF DEATH* was as follows:

Ilio Colitis

Myocardial degeneration (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) D. Arnold Miller M. D.

10/30 1927 (Address) 1570 W Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: London Park Oct — DATE OF BURIAL: 31 1927

20 UNDERTAKER: Franklin W Seitz — ADDRESS: 709 W 33rd St

OCT 31 1927 Per —

C. HAMILTON JONES, M.D.

NOTICE—Undertakers are strictly forbidden to issue burial permits unless the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-12-23—M&T—500 Blks.

E 26963 HEALTH DEPARTMENT—CITY OF BALTIMORE E 26963

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135. W. LAFAYETTE AVE. ST. OR WARD) 90

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Catesby Wise

(a) RESIDENCE NO. 135 W. Lafayette Ave. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Clarke Wise

6 DATE OF BIRTH (month, day, and year) Nov. 11, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	75	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince William Co. Virginia.

PARENTS

10 NAME OF FATHER Andrew D. Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Jane ~~Weston~~ Weston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) P.C. Wise Clarks Summit Pa.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1927.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1926. to Oct 30 1927.
that I last saw him alive on Oct 29 1927
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:
Prostatitis & General Debility

(duration) 1 yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? At Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J Rowland Gibson M. D.
, 19 (Address) Gibson Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	11-1 1927
20 UNDERTAKER	ADDRESS
H. W. Jenkins & Sons Co	Orchard McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26964

CERTIFICATE OF DEATH.

90 E 26964

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 207 Schenley Road St. 41-53 WARD)

2-FULL NAME George A. Hager.

(a) RESIDENCE No. 207 Schenley Road ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura K Hager

6 DATE OF BIRTH (month, day, and year): June 7 1850

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
77	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Maryland

PARENTS

10 NAME OF FATHER: Richard Hager

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Armacost

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Virginia M Hager

(Address) 207 Schenley Rd

15 Filed OCT 31 1927 19 RLR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1927, to Oct 30, 1927, that I last saw h/M alive on Oct 28, 1927, and that death occurred, on the date stated above, at 1.45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

Mitral insufficiency.

Aortic regurgitation

(duration) many years

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical symptoms

(Signed) R. B. Norment, M. D.

10-31-1927 (Address) 3643 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Balto Co Md

DATE OF BURIAL: Nov 1 19 27

20 UNDERTAKER: Wm. Slater Sons

ADDRESS: 330 Pine St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26965

CERTIFICATE OF DEATH.

REGISTERED NO. E 26965

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No.) ST. 16-68 WARD)

2-FULL NAME Patricia Mildred ~~Ann~~ Abbott

(a) RESIDENCE NO. 2513 W. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single - Baby

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER David R. Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Josephine Hannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Johns Hopkins Hospital

15 Filed ..... 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 • 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 23rd, 1927, to Oct 28th, 1927, that I last saw her alive on Oct. 28th, 1927, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. C. Goodwin, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cem	Oct 31 1927
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 26966

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1122 Calhoun St St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle Johnson

(a) RESIDENCE NO. 1122 Calhoun St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Johnson

6 DATE OF BIRTH (month, day, and year) Oct 23, 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Newbern N.C.

(State or country)

PARENTS

10 NAME OF FATHER Frank Green

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N.C.

12 MAIDEN NAME OF MOTHER Louise Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N.C.

14 Informant Mary Pearl

(Address) 1122 Calhoun St.

15 Filed ....., 19.. G. HAMPTON JONES, M. D. OCT 31 1927 Registrar

Per RMK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-1, 1927, to 10-29, 1927, that I last saw h[illegible] alive on 10-29, 1927, and that death occurred, on the date stated above, at 1.25 P m.

The CAUSE OF DEATH* was as follows:

Ulcerative enterocolitis

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) Chronic Pulmonary Phthisis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 1140 Pulaski St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frank K. Sanders, M. D.

10-4-1927 (Address) 1049 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial Nov 2 1927

20 UNDERTAKER Wm H. Carelton ADDRESS Hookstown

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 26967

CERTIFICATE OF DEATH.

E 26967

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 783 Sarah Ann St., 4-26 Ward)

2-FULL NAME Enoc Foo good

(a) RESIDENCE NO. 783 Sarah Ann St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriet Ann Foogood

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 35 Months ____ Days ____ IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer): _____

(c) Name of employer: _____

9 BIRTHPLACE (city or town): Elkridge

(State or country): Md

PARENTS

10 NAME OF FATHER: Charles Foogood.

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Anne Arundel Co. Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Unknown.

14 Informant: Harriet Ann Foogood

(Address): 783 Sarah Ann St.

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ____ yrs. ____ mos. 14 ds.

CONTRIBUTORY (Secondary) A Pausin

(duration) ____ yrs. ____ mos. 1 ds.

Oct 31/27 (Signed) G. C. Pitts M. D.

(Coroner)

19 (Address) 1436 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loftus Hill Cemetery E Chester Pa

Date of Burial: Oct 31, 27

20 UNDERTAKER: Leonard Whalen

ADDRESS: Box Marydel Md

Instruction should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B-P 36968 — 90

REGISTERED B-P 36968

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 1035 N. Eutaw St. 11-24 Ward)

2-FULL NAME Ella V. Hill

(a) RESIDENCE NO. 1035 N. Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1898

7 AGE — Years: about 29 | Months: | Days: | If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address): James Robinson 1035 N. Eutaw St.

15 Filed ....., 19 .... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct. 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): no other history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy (Coroner) M. D.

Oct. 30, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn | Date of Burial: Oct 31/27

20 UNDERTAKER: Daniel Easton | ADDRESS: Penna Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26969

161-001

CERTIFICATE OF DEATH

REGISTERED NO. E 26969

1-PLACE OF DEATH St Josephs Hospital

City of BALTIMORE: (No. Caroline & Ulrich St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby. Feldjesh.

(a) RESIDENCE NO. 2644 Huntington Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 9/17/27

7 AGE: Years | Months | Days | IF LESS than 1 day 5 hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of indostry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country) Ferdinand.

PARENTS

10 NAME OF FATHER F. Feldjesh.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore —

12 MAIDEN NAME OF MOTHER Alice Vockrodt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant

(Address)

15 Filed 19

Per

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

9/18/27

17 I HEREBY CERTIFY, That I attended deceased from 9/17, 1927, to 9/18, 1927,

that I last saw h alive on 9/18, 1927,

and that death occurred, on the date stated above, at 1.00 a. m.

The CAUSE OF DEATH* was as follows:

Premature 5½ month

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted? —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) James G. Voorhees, M. D.

10/28/27 19 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rest. St Josephs Cem.

Date of Burial 19

20 UNDERTAKER

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26970
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31 E 26970
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No.) 2703 E Fayette ST. 6-10 WARD)

2-FULL NAME Robert Goldman

(a) RESIDENCE No. 2703 E. Fayette ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Aug 22, 1905

7 AGE: Years 22 | Months 2 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Harry Goodman
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.
12 MAIDEN NAME OF MOTHER: Rosa Siegle
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Gustav Rodke 2703 E Fayette St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-29-27

17 I HEREBY CERTIFY, That I attended deceased from 6-1 .19 27. to 10-29 .19 27.
that I last saw h alive on 10-1 .27.
and that death occurred, on the date stated above, at 6 A m.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Finding
(Signed) 10-29-27 Robert Knight M. D.
(Address) 800 N Dallas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ist German United Evangelical Cem. | DATE OF BURIAL: Nov 1 1927.
20 UNDERTAKER: Wm E Fullerton | ADDRESS: 2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 31 1927

S[illegible]-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-802 E 26971

CERTIFICATE OF DEATH.

E 26971

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 520 N. Patterson Park Ave (St.) (Ward) 7-10

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis J. Reilly

(a) RESIDENCE NO. 520 N. Patterson Park Ave ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): Married

5a If married, widowed, or divorced
~~WIFE of~~ HUSBAND of Sophia Reilly

6 DATE OF BIRTH (month, day, and year) Nov. - 1874

7 AGE: Years 52 | Months 11 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stationary Eng.
(b) General nature of industry, business, or establishment in which employed (or employer) 320
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER Reilly
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Sophia Reilly
(Address) 520 N Patterson Park Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27 1927

17
I HEREBY CERTIFY, That I attended deceased from 10-22 1927 to 10-27 1927
that I last saw h[illegible] alive on 10-26 1927
and that death occurred, on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Influenza - acute
Endocarditis

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Finding
(Signed) Wm J Reed Reynolds M. D.
(Address) 801 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem — DATE OF BURIAL: Oct 31 1927

20 UNDERTAKER: Wm C. Miller & Son — ADDRESS: 2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

OCT 31 1927 [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26972

CERTIFICATE OF DEATH.

167-001

E 26972

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3601 Chestnut Ave ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby George

(a) RESIDENCE NO. 3601 Chestnut Ave ST.; 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29/27.

7 AGE: Years | Months | Days | If LESS than 1 day 28 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Maurice L. George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Elizabeth Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Ethel E. George

(Address) 3601 Chestnut Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct 29th 1927. to Oct 30th 1927.

that I last saw him alive on Oct 30th 1927.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(about 6½ mos.)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Malignant Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos. A. Sherwood, M. D.

Oct 30, 1927 (Address) 846 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. | DATE OF BURIAL: Nov 1 1927

20 UNDERTAKER: Ebenezer Smith Son | ADDRESS: Chestnut

Station should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26973

E 26973

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 29 E. Fort Ave. (ST.) 24-34 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Amelia Comegys.

(a) RESIDENCE NO. 29 E. Fort Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced
(or) WIFE of: William T. Comegys.

6 DATE OF BIRTH (month, day, and year): June 4, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: William Sapp.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know.

14 Informant: Ethel Ridge. (daughter)
(Address): 2707 Charlotta Ave.

15 Filed OCT 31 1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from September 15, 1927, to October 28, 1927,

that I last saw her alive on October 26, 1927

and that death occurred, on the date stated above, at 6.50 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -------

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Reinhardt, M. D.

10/29 1927 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Oct 31 1927

20 UNDERTAKER: John H. Denny — ADDRESS: 1155 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26974
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90

E 26974
REGISTERED NO.

City of BALTIMORE: (No. Little Sisters of the Poor St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Evans

(a) RESIDENCE NO. Preston & Valley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Evans,

6 DATE OF BIRTH (month, day, and year) Nov. 4 1854

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	72	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER George Rose

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Esthonia Nelson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St.

15 Filed OCT 31 1927 HAMSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov Dec 19..., to 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

Unknown (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Oct 31 1927 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — Date of Burial Nov. 2 1927

20 UNDERTAKER George W. Zickler — ADDRESS 1737 E. Eager St.

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 26975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117

E 26975 REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No. 76-77 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Krouse, Jr.

(a) RESIDENCE NO. 2676 Eagle St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 th 1923

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	4	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Herbert Krouse Sr.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) not given

12 MAIDEN NAME OF MOTHER not given

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) " "

14 Informant Herbert Krouse Sr.

(Address) 2676 Eagle St

15 Filed ..... 19 ..... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31 1927

17

I HEREBY CERTIFY, That I attended deceased from 10-29, 1927, to 10-31, 1927,

that I last saw h~~im~~ alive on 10-31, 1927,

and that death occurred, on the date stated above, at 4 25 a. m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix

Generalized peritonitis

(duration) ....yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/29/27.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. L. Dalyhacca, M. D.

, 19 (Address) St Agnes' Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery Date of Burial Nov. 3 1927

20 UNDERTAKER: George E. Schwab ADDRESS 2501 Eutaw Ave.

C. H. Hampson Jones, M. D.

OCT 31 1927

Registrar

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 26976 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 26976

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1255 Riverside Ave (ST.) 24-34 (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V Bienlein

(a) RESIDENCE NO. 1255 Riverside Ave ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 10 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	18	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John A Bienlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ella Forstman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John A Bienlein
(Address) 1255 Riverside Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1927

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to Oct 29, 1927,

that I last saw h[illegible] alive on Oct 29, 1927

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A Schenuick, M. D.

19 (Address) 1337 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A A Co — DATE OF BURIAL 11-2 1927

20 UNDERTAKER E H Hale — ADDRESS 115 E Mt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ALL blanks should be filled EXACTLY. PHYSICIANS should state

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E-26977

179 E 26977

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital St., 10-W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nora Corghan

(a) RESIDENCE NO. 1217 Wilcox St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14/27

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Edward Corghan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Barret

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Nora E. Corghan

(Address) 1217 Wilcox

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Oct 30-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia - Accidently burnt by hot water bottle after birth

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. C. Weber M. D.
(Coroner)

19 (Address) 10-31-27 504 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New Cathedral Cemetery	Nov 3 / 1927

20 UNDERTAKER	ADDRESS
George F. Ruth	1735 Harford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 26978

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2933 E. Monument St. - 11 Ward) 1

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E. Vitocolonna

(a) Residence No. 2933 E. Monument st St., Ward 7

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Armando Vitocolonna

6-DATE OF BIRTH (month, day and year) March 12th 1898

7-AGE. 29 yrs. 7 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Henry Thune

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Minnie Hoensch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Johanna Dresor

(Address) 322 N. Monroe st

15-

Filed ..... 192 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 30/27

17- I HEREBY CERTIFY, That I attended deceased from Oct. 28 1927 to Oct. 30 1927

that I last saw h.e alive on Oct. 30 1927

and that death occurred, on the date stated above, at 1 10 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fr. Artigiani M. D.

1927 (Address) 2942 E. Fayette st

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL. Oct 31 1927

20-UNDERTAKER. Frank V. Pepetone

ADDRESS 2518 E. Baltimore st

OCT 31 1927 Harrison Jones M.D.

Dft $100.00

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26979 100-001 E 26979

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 No. Glover St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Ihniowski,

(a) RESIDENCE NO. 6 No. Glover St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 22- 1927.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	0	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None, J.H.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) MD.

PARENTS

10 NAME OF FATHER Vicent J. Ihniowski,

11 BIRTHPLACE OF FATHER (City or town) Bay City,
(State or country) Miss.

12 MAIDEN NAME OF MOTHER Dora M. Sidler,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) MD.

14 Informant Vincent J. Ihniowski, (Father)
(Address) 6 No. Glover Street

15 Filed ..... 19 ..... Registrar

OCT 31 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29/27 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 29 19 27 to Oct 29 19 27

that I last saw him alive on Oct 29 19 27

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted at home

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) Louis Vogel, M. D.

10/30/27 (Address) 2601 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Stanislaus Cem	Oct 31-1927
20 UNDERTAKER M J Sadowski.,	ADDRESS 705 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 26980 ✓ 90 E 26980

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1618 E. Biddle St., 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle Robinson

(a) RESIDENCE NO. 1618 E Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8, 1855

7 AGE Years: 72 Months: 7 Days: 20 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Balto.

(State or country)

PARENTS

10 NAME OF FATHER Wm. Robinson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Eliza May

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Mrs. Carl C. Robinson

(Address) 1618 E. Biddle St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 27, 1927

that I last saw her alive on Oct 27, 1927

and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. 12 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 12 mos. ..... ds.

18 Where was disease contracted Home & Hospital

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

(Address) 1403 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

Date of Burial: Oct. 31, 1927

20 UNDERTAKER: John C. Mitchell Sons

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

E 26981

REGISTERED NO. E 26981

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

City of BALTIMORE: (No.) Sinai Hosp St. 14-20 Ward

2 FULL NAME Charles Sperling

(a) RESIDENCE NO. 2047 Penna Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freda

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing store

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Esther Ries

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant: Freda Sperling

(Address) 2047 Penna. Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10/30/27

17

I HEREBY CERTIFY, That I attended deceased from 10/23, 1927, to 10/30, 1927, that I last saw him alive on 10/30, 1927, and that death occurred, on the date stated above, at 11.48 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ...yrs. ...mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes - Gen. arteriosclerosis Cerebral Thrombosis

What test confirmed diagnosis?

(Signed) Meyer Weller, M. D.

(Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — Date of Burial 10/31/1927

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Balto St

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26982

CERTIFICATE OF DEATH

90 E 26982

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2677 Wilkens Ave. St. 21-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Moxley

(a) RESIDENCE NO. 2677 Wilkens Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days IF LESS than 1 day ..... hrs. or ..... min..

About 65

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleswoman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Perry Moxley

11 BIRTHPLACE OF FATHER (City or town) Martinsburg

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen Mullineux

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co.

(State or country) Md.

14 Informant W. F. Moxley

(Address) 2677 Wilkens Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October 28, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1927, to Oct 27, 1927, that I last saw her alive on Oct 27, 1927, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Febrinid Pneumonia

Antecedents ..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (acute)

..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

Oct 30. 1927 (Address) 2677 Wilkins Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — Date of Burial 10/31/ 19

20 UNDERTAKER Leopold Cook — ADDRESS 1003 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 26983

REGISTERED NO.

11-24

1-PLACE OF DEATH

City of BALTIMORE: (No. 1227 Linden Avenue St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Pennington

(a) RESIDENCE NO. 1227 Linden Avenue St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Jennie R. Pennington

6 DATE OF BIRTH (month, day, and year) September 26, 1835

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	92	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cecil County

(State or country) Maryland

PARENTS

10 NAME OF FATHER Noble Pennington

11 BIRTHPLACE OF FATHER (City or town) Cecil Co.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Morgan

13 BIRTHPLACE OF MOTHER (city or town) Cecil County

(State or country) Maryland

14 Informant Miss Nancy Pennington

(Address) 1227 Linden Avenue

15 Filed ..., 19 ... Registrar

OCT 31 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1917, to Oct 29, 1927, that I last saw him alive on Oct 28, 1927, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Pneumococcus type 4)

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1227 Linden Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical sign & Lab. test

(Signed) Jno A Luetscher, M. D.

, 19 (Address) 12 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial 10/31/27 19

20 UNDERTAKER Robt B Cook — ADDRESS 1037 W. Baltimore St

Spec.–7-17-26—A Co.—200 Bks.

E 26984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 26984

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 5 South Hilton St. 20-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kroehs

(a) RESIDENCE NO. 5 South Hilton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustav. A. Kroehs

6 DATE OF BIRTH (month, day, and year) June, 20th. 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	69	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At home

9 BIRTHPLACE (city or town) Richmond

(State or country) Virginia

PARENTS

10 NAME OF FATHER Valentine Fenner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Miss Mary Fenner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant William C. Kroehs

(Address) 5 South Hilton Street

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

October, 30th. 1927

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1927, to Oct 30, 1927,

that I last saw her alive on Oct 30, 1927,

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. & Phy. exam

(Signed) Fred T. Kruer M. D.

10/31 19 27 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

Date of Burial 11/2/27 19

20 UNDERTAKER Joseph B. Cook

ADDRESS [illegible] Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 26985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x 46 E 26985

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Murphy

(a) RESIDENCE NO. La Plata, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): November 1882

7 AGE: Years 45 Months 11 Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): La Plata

(State or country): Md.

PARENTS

10 NAME OF FATHER John Murphy

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Kate Lynch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mo.

14 Informant Dolor E. Murphy

(Address) La Plata, Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10/30/27

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 19 27 to Oct. 30, 19 27, that I last saw h[illegible] alive on Oct. 20, 19 27, and that death occurred, on the date stated above, at 9:55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral tumor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. Lawrence Fabian, M. D.

10/31, 1927 (Address) St. Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: La. Plata, Md. Date of Burial Nov. 1 1927

20 UNDERTAKER: Geo. R. Cook ADDRESS 1003 E. Main St. La Plata

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 31 ... C. HAM[illegible]

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26986

CERTIFICATE OF DEATH.

24 E 26986

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 10-14 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvin Powell

(a) RESIDENCE NO. 1217 E Madison St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) MD

PARENTS

10 NAME OF FATHER Edward Powell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Emma KKKKK

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Hopkins

(Address)

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 29-27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute meningitis

(Probably Meningococcus)

(Autopsy)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Rollins M. D.
(Coroner)

10-31-19 27 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Cedarcroft Lawn. 10/31 1927.

20 UNDERTAKER — ADDRESS

E Bruzzi 1631 Eutaw.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 26987

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 26987

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2837 St Paul St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A Walter

(a) RESIDENCE NO. 2837 St Paul St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 7, 1861

7 AGE — Years: 66 Months: 9 Days: 23 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Henry Bell

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Small

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: John W. Walter

(Address): 2837 St Paul St

15 Filed OCT 31 1927, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 — 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927, to Oct 30, 1927, that I last saw h[er] alive on Oct 30, 1927, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas F Stolte, M. D.

Oct 31, 1927 (Address) 502 Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Greenmount Cem	Nov 1 1927
20 UNDERTAKER: George F Smith	ADDRESS 532 Wilkins Ave

Spec. 12-9-25—A Co.—200 Bks. Sarah Elizabeth Emmerich

E 26988

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 26988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital 25-72 REGISTERED NO.

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Emmerick

(a) RESIDENCE NO. 30 Annapolis Ave St. Ward

(Usual place of abode) Mt Wrans (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Emmerick

6 DATE OF BIRTH (month, day, and year): August 28 1865

7 AGE: Years 62 Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (city or town)

(State or country) " "

12 MAIDEN NAME OF MOTHER

" "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) " "

14 Informant Henry J Emmerick

(Address) 30 Annapolis Ave Mt Wrans

15 Filed....., 19.....

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-11, 1927, to 10-28, 1927, that I last saw h.e alive on 10-28, 1927, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Di Padaylacca, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial Oct 31 1927

20 UNDERTAKER: Harry N. Witzke ADDRESS 532 W. Lombard

N. B.—WRITE PLAINLY, WITH FADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Letter in file dated Nov 2-1927 from undertaker

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26989

CERTIFICATE OF DEATH.

185 E 26989

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospital ST. 13-57 WARD)

2-FULL NAME Margaret Clark.

(a) RESIDENCE NO. 3409 Chestnut ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles F Clark

6 DATE OF BIRTH (month, day, and year): Don't know

7 AGE: Years 80-86; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: C. F. Clark Jr.

(Address) 1232 Druid Hill Ave

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1927. to Oct 30, 1927.

that I last saw h[illegible] alive on Oct 29, 1927

and that death occurred, on the date stated above, at 8 45 a m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis, Chronic Myocarditis, Intracapsular Fracture Left Femur - (Fell walking down hall accidentally)

(duration) yrs Unknown mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? Accident occurred in hospital

Did an operation precede death? Yes Date of Oct. 20, 1927

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Physical Signs.

(Signed) [illegible], M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Nov 1 1927

20 UNDERTAKER: [illegible]

ADDRESS 2008 Orleans.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.P.S.—400 Bks.

E 26990

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26990

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

City of BALTIMORE: (No. 504 N Gilmore St. 19-27 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Smith.

(a) Residence No. 504 N. Gilmore St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black.

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 29, 1927

7-AGE, ... yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Nil.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Irving Alexander Smith

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Evangeline Jordon

13-BIRTHPLACE OF MOTHER (city or town) St Mary's Co. (State or Country), Md.

14- (Informant) .....

(Address) .....

15- Filed ..... 19.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 30 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1927 to Oct 30 1927

that I last saw him alive on Oct 30 1927

and that death occurred, on the date stated above, at 6P m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

..... (Duration) ..... yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Phy exam.

(Signed) Knight Reynolds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, ... 19....

20-UNDERTAKER, ADDRESS

JOHNS HOPKINS HOSPITAL

DEC 31 1927

C. HAMPSON JONES, M. D.

OCT 31 1927

Dr. Knight Reynolds.

3-5

4260

Stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

26991

74 E 26991

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., ____ Ward)

2-FULL NAME John J Munson

(a) RESIDENCE NO. 3528 Calvert St Balt. Md. St., ____ Ward

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single, Married~~, Widowed, or ~~Divorced (write the word)~~: Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henrietta J. Munson

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): " " "

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): " " "

14 Informant: Robert Brooks

(Address): 17 E. Calhoun St

15 Filed....., 19.... HAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28th 1927

17 I HEREBY CERTIFY, That I attended deceased from October 26, 1927, to October 28, 1927, that I last saw him alive on Oct. 28, 1927, and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis — Hypertension

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) A. J. Knapp, M. D.

10-28, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — Date of Burial: Nov 1st 1927

20 UNDERTAKER: Robert Brooks & Son — ADDRESS Cor Calhoun Fulton

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be strictly OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

(Garrew)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26992

CERTIFICATE OF DEATH.

181-001 E 26992

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1309 N Charles St., 11-19 Ward)

2-FULL NAME Earl G Harvey

(a) RESIDENCE NO. 1309 N. Charles St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24, 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	5	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chiropractor
(b) General nature of Industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Florida
(State or country)

PARENTS

10 NAME OF FATHER E L Green
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.
12 MAIDEN NAME OF MOTHER A. Godfrey
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant Earl G. Harvey
(Address) 1309 N. Charles St

15 Filed ..... 19 ..... Registrar

Fee 0.00

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 21 19 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Valvular disease Heart
Arteriosclerosis
Cardiac Degeneration
and Pulmonary Tuberculosis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

Oct 31 (Signed) A. T. Pelley M. D.
(Coroner)
, 19 (Address) 1039 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camden N J — Date of Burial Nov 2 19

20 UNDERTAKER — ADDRESS 502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 31 1927 C. HAMPSON JONES M.D.

Spec.—1-12-23—M&T—500 Bks.

(Ramon) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26993 E 26993

CERTIFICATE OF DEATH.

118-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospital St. 26-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mike Romeo

(a) RESIDENCE NO. Balto City Hospital St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Roman

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE: Years 42 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Michael Ramon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Antonnow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant John Ondak (Address) 55 South 11th St

15 Filed Oct 11, 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31, 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 18, 1927, to Oct 31, 1927,

that I last saw him alive on Oct 31, 1927

and that death occurred, on the date stated above, at 7:45 a m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

Right Inguinal

Chronic Myocarditis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct. 18, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. Meyerding M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Grove Cem DATE OF BURIAL 11 5 1927

20 UNDERTAKER W. H. Cook ADDRESS 502 E. North Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26994

CERTIFICATE OF DEATH.

E 26994

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2631 Oak St. (Ward) 12-51

2-FULL NAME William J. Fillmore

(a) RESIDENCE No. 2631 Oak St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Fillmore

6 DATE OF BIRTH (month, day, and year) Aug 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	66	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician 29

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railroad

9 BIRTHPLACE (City or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Unknown

14 Informant Mrs Emma Leitner

(Address) 2631 Oak St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 28 , 1927 , to Oct 30 , 1927 , that I last saw him alive on Oct 30 , 1927 , and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. L. Gross, M. D.

, 19 (Address) 28 W. 23 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 11/2 1927

20 UNDERTAKER Wm Cook — ADDRESS 502 East Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26995

CERTIFICATE OF DEATH.

57 E 26995

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 12-14 Ward)

2-FULL NAME Thomas H. Green

(a) RESIDENCE NO. 170 Guilford Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17/68

7 AGE	Years	Months	Days	IF LESS than 1 day __hrs. or__min.
	59	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Green

11 BIRTHPLACE OF FATHER (city or town)

(State or country) MD

12 MAIDEN NAME OF MOTHER Rebecca Kirkhead

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Margaret N. Green
(Address) 1705 Guilford Ave

15 Filed_____ 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) ____yrs. ____mos. ____ds.

CONTRIBUTORY (Secondary) Diabetes Mellitis

(duration) ____yrs. ____mos. ____ds.

(Signed) John Cullen M. D.
(Coroner)

10/31-27 19 (Address) 508 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death __yrs.. __mos.. __ds. In the State __yrs.. __mos.. __ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Bethel Cem Hayford Co Date of Burial 11-1- 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

E 26996

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26996

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Childrens Hosp School St. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alma Lantz

(Residence in Baltimore: No. 1425 Henry St. Balto. Md. St.; 19 yrs., 3 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. July (Month) 26th (Day), 1908 (Year)

7-AGE. 19 yrs. 3 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Student
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Howard Wheatley Lantz

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER (Deceased) Mary E. Hirsch

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laurence B. Chenoweth M.D.

(Address) Childrens Hosp. School

15-

Filed....., 192..

C. HAMPSON JONES, M. D. Registrar.

OCT 31 1927 Per BRR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 31st, 1927. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 27 1927. to October 31st 1927. that I saw h-er alive on October 31st. 1927, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous of Spine
Psoas Abscess
Tuberculosis Generalized (Liver and Lungs)
Abscess of mastoid
(Duration) 18 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous abscess of gland
mastoid region (right)
(Duration) yrs. mos. ds.

(Signed) Laurence B. Chenoweth M. D.

Oct. 31, 1927 (Address) Childrens Hosp. School

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 5 ds. In the State 19 yrs. 3 mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Union Cem. DATE OF BURIAL, 11-3....., 192..

20-UNDERTAKER Wilson Cook ADDRESS 502 E. Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26997

CERTIFICATE OF DEATH.

× 101-001 E 26997

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. New Hospital St. 4-30 Ward)

2-FULL NAME Doaman Din Majid

(a) RESIDENCE NO. At Shop Myrtle Faulk St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. mos. 7 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 25 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Liverpool

9 BIRTHPLACE (city or town) _____ (State or country) India

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Unknown

14 Informant: Harvey Scarlett Co

(Address) Eastern Ave & Canton

15 Filed _____, 19___ Registrar R.F.H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ___ yrs. ___ mos. 14 hrs

CONTRIBUTORY (Secondary) Alcoholism

(Duration) ___ yrs. ___ mos. 1 hr

(Signed) G. E. Blades M. D.

(Corner)

Oct 31/27 19 (Address) 1343 N. Penna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem Balto Date of Burial 19 27

20 UNDERTAKER: John C. Mitchell Sons ADDRESS: 1 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26998

100-E 26998

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 46-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Durfee

(a) RESIDENCE NO. 400 Pounder St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — — 1873

7 AGE 54 Years Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (City or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address)

15 Filed ..., 19 ... Registrar

OCT 31 1927 Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-19, 1927, to 10-26, 1927, that I last saw him alive on 10-26 1927, and that death occurred, on the date stated above, at 11 55 P m.

The CAUSE OF DEATH* was as follows:

Methyl Alcohol Intoxication

Bronchopneumonia

Alcoholism, acute

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Phys. Examination

What test confirmed diagnosis?

(Signed) W. W. Chrisman, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem Date of Burial 11/1 1927

20 UNDERTAKER J. F. Shaughnessy ADDRESS 1318 Eye St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 26999 ✓ E 26999

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Franklin's Westfield Rd. 1925

City of BALTIMORE: (No. Hillsdale Basic dist. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward H. Engelman

(a) RESIDENCE NO. Hooks Lane, Elkridge, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hilda Engelman

6 DATE OF BIRTH (month, day, and year) September 4, 1891

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
36	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Kaufman Beef Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Engelman

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Fink

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Hilda Engelman

(Address) Hooks Lane, Elkridge, Md.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gun shot wound in head probably instant death

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Heuisler M. D. (Coroner)

(Address) 2572 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

New Cathedral Cemetery 11/1 1927

20 UNDERTAKER Robert Cook ADDRESS 1003 W. Baltimore St.

NOV 1 - 1927

C. HAMILTON M.

Reg.

be stated EXACTLY. AGE should be stated. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27000

CERTIFICATE OF DEATH

74001 E 27000

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1224 Bolton St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annetta L. Wagner

(a) RESIDENCE NO. 1224 Bolton Street St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George H. Wagner

6 DATE OF BIRTH (month, day, and year): February 9, 1861

7 AGE — Years: 66 Months: 8 Days: 21 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Howardville, Balto Co.

(State or country): Maryland

PARENTS

10 NAME OF FATHER: George H. Hood

11 BIRTHPLACE OF FATHER (City or town): Howardville

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah E. Fishpaw

13 BIRTHPLACE OF MOTHER (city or town): Pikesville

(State or country): Maryland

14 Informant: Wm. L. Brooks

(Address): Pikesville, Md.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: October 30, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 30, 1927, that I last saw her alive on Oct 30, 1927, and that death occurred, on the date stated above, at 11.55 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Evans M. D.

10/31 19 27 (Address) 1425 Linden Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery Date of Burial Nov 2nd 1927

20 UNDERTAKER: Chas. H. Cook ADDRESS 1003 W. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Blks.

627001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Betty Barker

(a) RESIDENCE NO. Middlesex St, Helen Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-9-25

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Cathleen White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Oct 29, 1927, that I last saw her alive on Oct 29, 1927, and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Cystitis

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Acidosis & nitrogen retention

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of -

Was there an autopsy? yes

What test confirmed diagnosis? Urine + blood chemistry

(Signed) W. C. Goodwin M. D.

19 ..... 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 11/1 1927

20 UNDERTAKER Philip Henry

ADDRESS 2016 Orleans

CAUSE OF DEATH in ... terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27002

CERTIFICATE OF DEATH.

74-001

E 27002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No. 3508 Edgewood Road ST.) 15-62 (WARD)

2-FULL NAME John Parker

(a) RESIDENCE NO. 3508 Edgewood Road. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Parker

6 DATE OF BIRTH (month, day, and year) Nov. 9, 1852.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Librarian.

(b) General nature of industry, business, or establishment in which employed (or employer) Library.

(c) Name of employer Peabody Institute

9 BIRTHPLACE (city or town) New York

(State or country) New York.

PARENTS

10 NAME OF FATHER James M. Parker

11 BIRTHPLACE OF FATHER (city or town) Dungarvon

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Mary

13 BIRTHPLACE OF MOTHER (city or town) ~~Dublin~~

(State or country) Ireland

14 Informant Mrs. W. J. R. Benham

(Address) The Envil.

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1927, to Oct 31 1927, that I last saw him alive on Oct 30 1927, and that death occurred, on the date stated above, at 2-30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. Gill Hall M. D.

Oct 31 1927 (Address) 1631 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Nov 2 1927

20 UNDERTAKER: John B. Spence — ADDRESS: 1325 N. Caroline St

NOV 1 1927 C. HAMPSON, M.D.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27003 — 129 — E 27003

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospital 13-5 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Walton Gear

(a) RESIDENCE NO. 228 E. 26th St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. / mos. 22 ds. How long in U. S. if of foreign birth? 14 yrs. / mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1913

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	14	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) School-Boy.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER William Gear

11 BIRTHPLACE OF FATHER (City or town) Kent Co. Md

(State or country)

12 MAIDEN NAME OF MOTHER Luella Elpming

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Hospital Records

(Address)

15 Filed NOV 1 1927, 19 R. H. [illegible] Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 19 27, to Oct 30, 19 27

that I last saw h/M alive on Oct 30, 19 27

and that death occurred, on the date stated above, at 12.07 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardio-vascular Renal disease (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Geo. A. Tompkins, M. D.

, 19 (Address) 1 W. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial Nov 2 1927

20 UNDERTAKER S. [illegible] & WOODEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 103 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOV 1 1927 C. HEALTH DEPT.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27004 — 46 E 27004

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4 Plymouth Rd ST. Homelea WARD) 27-43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie C Lwante

(a) RESIDENCE No. 4 Plymouth Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William C Lwante

6 DATE OF BIRTH (month, day, and year): Aug 12, 1881

7 AGE — Years: 46 — Months: 2 — Days: 18 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John England

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Lulu Bachman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): William C Lwante 4 Plymouth Road

15 Filed ..... 19 ..... Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Oct 30, 1927, that I last saw h[er] alive on Oct 30, 1927, and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

Interne Ceremonia

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) interne Ceremonia

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Geary A Long, M. D.

(Address) 7316 Harford Rd Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pachman — DATE OF BURIAL: 11/2 1927

20 UNDERTAKER: W. H. Cook — ADDRESS: 6028 Harford

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27005 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27005

CERTIFICATE OF DEATH.

118-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 1-2 WARD)

2-FULL NAME Mrs Kathryn HARPER

(a) RESIDENCE NO. 646- S Decker ST. 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Frank L. & C. HARPER

6 DATE OF BIRTH (month, day, and year) Mar 7, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	62	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wolfgang Kohler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Bastian

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Franklin E. Harper (Address) 646 S Decker Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1927, to Oct 30, 1927, that I last saw h e v alive on Oct 30, 1927 and that death occurred, on the date stated above, at 2 Pm

The CAUSE OF DEATH* was as follows:

Strangulated Hernia.

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) Diabetes - Coronar Sclerosis.

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 30, 1927

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) W. D. Hannah, M. D.

, 19 (Address) 33½ Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery. DATE OF BURIAL Nov 2nd 1927

20 UNDERTAKER Lilly & Zeller ADDRESS [illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 27006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 27006

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3713 E Lombard ST., 26 WARD

2-FULL NAME George W. Nellet.

(a) RESIDENCE NO. 3713 E. Lombard ST., 26 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (a) HUSBAND of (or) WIFE of: Katharine T. Nellet.

6 DATE OF BIRTH (month, day, and year): Sept. 29th 1886

7 AGE: Years 41; Months 1; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Potter at.

(b) General nature of industry, business, or establishment in which employed (or employer): Bennetts

(c) Name of employer: Pottery

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Philip Nellet

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Christina Abt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Katharine T. Nellet (Address) 3713 E Lombard St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 18 , 1927 , to Oct 29 , 1927, that I last saw h[illegible] alive on Oct 28 , 1927, and that death occurred, on the date stated above, at 6:20 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Lungs.

CONTRIBUTORY (Secondary) (duration) 1 yrs. mos ds. Myocarditis

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. L. Mayer M. D.

(Address) 1612 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Nov 2 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 1033 Wash. Ave

USE PLAIN WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27007

CERTIFICATE OF DEATH.

166

E 27007

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Colored Hosp St. 15-58 Ward)

2-FULL NAME Susie Bell Richter

(a) RESIDENCE NO. 2816 Oswego Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Harry C Richter

6 DATE OF BIRTH (month, day, and year): Sept 6, 1898

7 AGE — Years: 29 | Months: 11 | Days: 24 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nov 4, 1927

(State or country) Md

PARENTS

10 NAME OF FATHER H Frank Rosemond

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Susie Talbot

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Harry Richter

(Address) 2816 Oswego Ave

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct. 30, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Alcoholism of many yrs

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Lunacy M. D.

(Coroner)

(Address) 25 E Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Lawn Cem Date of Burial Nov 2, 1927

20 UNDERTAKER: Chas Troy Stiffler ADDRESS 1555 Mott Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RESERVED FOR BINDING

NOV 1 - 1927

Spec.—1-12-23—M&T—500 Bks.

E 27008 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27008

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 908 Chauncey ave St., 13-59 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellis Lachman

(a) RESIDENCE NO. 908 Chauncey ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 35 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude Lachman

6 DATE OF BIRTH (month, day, and year): Jan 21-1875

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
52	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cafe Mfg

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Yerik Lachman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address): 1409 E Balt St

15 Filed ..... 19 ..... HAWKINS, M. D. Registrar

by RMK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/1 19 27

17

I HEREBY CERTIFY, That I attended deceased from Oct 24, 1927, to Oct 31, 1927,

that I last saw him alive on Oct 31, 1927,

and that death occurred, on the date stated above, at 12-15-a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos 6 ds.

CONTRIBUTORY (Secondary): myocarditis incipient

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis Lachman M. D.

, 19 (Address) 1810 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 11/1 19 27

20 UNDERTAKER: Jack Lewis

ADDRESS: 1409 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

E 27009

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27009

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Home for Incurable, ST. 13-52 WARD)

2-FULL NAME Elizabeth A. Benville

(a) RESIDENCE NO. 40th St. & Cedar Ave. ST., Balto. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) ? ? 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	80	?	?	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hillsdale, Balto Co. Maryland

PARENTS

10 NAME OF FATHER John Benville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montreal Canada

12 MAIDEN NAME OF MOTHER Sarah Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Mrs. J. Lace (Address) 72 E. North Ave

15 Filed NOV 1927, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 19 27

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1920, to Oct 29, 1927.

that I last saw her alive on Oct. 29, 1927.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis over 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam & laboratory methods

(Signed) Wm Brady, M. D.

10/30, 1927 (Address) Med. Arts Bldg - Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Nov 1 1927

20 UNDERTAKER W. Tucker Sons

ADDRESS Forest

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27010

E 27010

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 109 E. 32nd St. (ST.) 17-50 (WARD)

2-FULL NAME Sarah Elizabeth Bisley

(a) RESIDENCE NO. 109 E. 32nd St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William J. Bisley

6 DATE OF BIRTH (Month, day, and year): June 15th 1835

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
9	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md

PARENTS

10 NAME OF FATHER: Jos. Germain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah E. M. Collon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Howard S. Bisley

(Address) 2836 St. Paul St.

15 Filed NOV 1 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 1927 to Oct 30 1927, that I last saw h[illegible] alive on Oct 30 1927, and that death occurred, on the date stated above, at 9 20 P. m.

The CAUSE OF DEATH* was as follows: Chronic Endocarditis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. L. Packard M. D.

(Address) 620 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 11/1 1927

20 UNDERTAKER: Wm. J. Jackson & Son

ADDRESS: Balto Md

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 1 1927

Cor.—12-9-25—A Co.—200 3ks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27011

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

162 E 27011

REGISTERED NO._____

City of BALTIMORE: (No. St. Joseph Hospital St., 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Barbara Ann Scheler

(a) RESIDENCE NO. Fulerton, Md. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22/27

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Co., Md.

PARENTS

10 NAME OF FATHER Leonard B. Scheler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Agnes E. Braid

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Leonard B. Scheler

(Address)

15 Filed_____, 19____ NOV 1 1927 C. H. [illegible] Registrar

Per_____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronco-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Kallos M. D.

(Coroner)

11/1, 19 27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery Date of Burial Nov. 1, 1927

20 UNDERTAKER Frederick Lasselander ADDRESS Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27012

143-9 E 27012

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Fuchs

(a) RESIDENCE NO. 2452 McCulloh St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rufus Fuchs

6 DATE OF BIRTH (month, day, and year): Jan 19–1897

7 AGE — Years: 30 Months: 9 Days: 10

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Marshall

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Robinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant: Rufus Fuchs
(Address) 2452 McCulloh

15 Filed ..... 19 ..... Registrar

NOV 1 - 1927 C. HA...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

10-29-27

17 I HEREBY CERTIFY, That I attended deceased from 10-21- 1927, to 10-29- 1927, that I last saw h-r alive on 10-29 1927, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Ectopic pregnancy o- ruptured before Section Desire dilatation of-

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/23/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. J. Eastman M. D.

10/29 19 27 (Address) 5 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial 11/1/27

20 UNDERTAKER: Geo H. Holland — ADDRESS 1401 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27013

31 E 27013

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals St., 5-B WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tom Blake

(a) RESIDENCE NO. 1116½ E. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Steve Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Laura Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address)

15 Filed 10-28-27, 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 19 27, to Oct. 27, 19 27, that I last saw h im alive on Oct. 27, 19 27 and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) J. E. Madden M. D.

19 27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 11/1 19 27

20 UNDERTAKER Byron Wright

ADDRESS 1218 McCulloh St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27014

CERTIFICATE OF DEATH.

33

E 27014

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 97-44 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sallie Harkins

(a) RESIDENCE NO. 5009 Augusta Ave. St. Hamilton Md. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. — mos. 13 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard F. Harkins

6 DATE OF BIRTH (month, day, and year): Oct 17, 1870

7 AGE — Years: 57 yrs. — Months: — — Days: 13 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House duties

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: John W. Hood

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Alberta McMaster

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: James M. Harkins

(Address) 5009 Augusta Ave

15 Filed ..... 19.. NOV 1 1927 C. HEALTH OFFICER M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1927, to Oct 30th, 1927, that I last saw her alive on Oct 30th, 1927, and that death occurred, on the date stated above, at 11.25 A. m.

The CAUSE OF DEATH* was as follows: Tuberculous Peritonitis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 24th 1927

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) F. D. Badagliacco, M. D.

, 19 (Address) St Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Nov. 2. 1927

20 UNDERTAKER: Chas. O. Stitely & Sons

ADDRESS: Pikesville Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

27015

101-001 E 27015

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. South Baltimore General Hospital. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles A. Norton.

14-33

(a) RESIDENCE NO. 1207 Durst Alley. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) August 15, 1926.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Norman E. Norton.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Rosa Becker.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Norman E. Norton. (father)

(Address) 1207 Durst Alley.

15 Filed NOV 1 1927 (C. HARRY JONES, M. D.) Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 31, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto Leonhardt M. D.

(Corner)

11/1 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 11-2 1927

UNDERTAKER E. T. B. Hale ADDRESS 115 E. Read St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27016

CERTIFICATE OF DEATH.

E 27016

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 17-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian Allender

(a) RESIDENCE NO. 1006 N. Wolfe st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Allender

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Washington (State or country) D.C.

PARENTS

10 NAME OF FATHER Emanuel Sharp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Alice Alexander

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D.C.

14 Informant Hospital Records

(Address)

15 Filed , 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1927 to Oct. 29, 1927,

that I last saw her alive on Oct. 29, 1927

and that death occurred, on the date stated above, at 2.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) A. E. Madden M. D.

10-29-27, 19 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cem.	Nov. 1, 19 27
20 UNDERTAKER Wm. R. C. Elliott	ADDRESS 225 N. Gilmor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27017

CERTIFICATE OF DEATH.

12 9 E 27017

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 S. Belnord Ave ST., 7-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schultz Brodyhouse

(a) RESIDENCE No. 520 S. Belnord Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James G. Brady house

6 DATE OF BIRTH (month, day, and year): April 24-09

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundry 067

(b) General nature of industry, business, or establishment in which employed (or employer): Sutzler Bros

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Peter Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Bombrowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: James G. Brady house

(Address) 520 S. Belnord Ave

15 Filed ..., 19 .. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1927, to Oct 28, 1927, that I last saw her alive on Oct 28, 1927 and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Acute hypocerdite

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Heart murmurs

(Signed) Thos H Phillips, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Nov 2-27 19

DATE OF BURIAL

20 UNDERTAKER: F. W. Ozazewski

ADDRESS 1930 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27018

CERTIFICATE OF DEATH.

90 E 27018

1-PLACE OF DEATH Franklin Square Hosp. 18-1 REGISTERED NO.

CITY OF BALTIMORE: (No. Calhoun & Fayette St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Scully

(a) RESIDENCE NO. 933 W Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10-1879

7 AGE: Years 48 Months 6 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md Co

PARENTS

10 NAME OF FATHER James Scully

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen North

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Charles E Scully
(Address) 933 W. Balto St

15 Filed , 19 By RHL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 , 1927, to Oct 31 , 1927,

that I last saw h alive on Oct. 31 , 1927,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Terminal broncho pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic alcoholism, arteriosclerosis, myocarditis (duration) , yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Elizabeth B Shuman, M. D.

, 19 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Grave, DATE OF BURIAL 11/2 1927

20 UNDERTAKER Wm Cook ADDRESS 502 E Mont

NOV 1 1927 C. HAWOOD JONES, M. D.

ALL ENTRIES MUST BE MADE IN INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

27019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 27019

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1339 Dolphin St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Caroline Pate

(a) RESIDENCE NO. 1339 Dolphin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm R. Pate

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 57 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country):

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Fred K. Pate

(Address): 1339 Dolphin St

15 Filed ..... 19 ..... Registrar

NOV 1 1927 C. EMERSON JONES, M. D. Per ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 26 1927 to Oct 31 1927, that I last saw her alive on Oct 31 1927, and that death occurred, on the date stated above, at 10 AM m.

The CAUSE OF DEATH* was as follows:

Tetanus Traumatic

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Toxemia, Uremia

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Elliott M. D.

11-1 1927 (Address) 2 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa — Date of Burial: Nov 2 1927

20 UNDERTAKER: Sam'l H. Clarke Son — ADDRESS: 1400 Myrtle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27020

CERTIFICATE OF DEATH.

36-005
E 27020

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Cairo St St.: 19-26 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beulah Hicks

(Residence in Baltimore: No. 1411 Cairo St St.: 2 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown, 1901
(Month) (Day) (Year)

7-AGE, 26 yrs.. mos.. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER William Hicks

11-BIRTHPLACE OF FATHER (State or Country), N. C

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Gault

(Address) 1411 Cairo St

15- C. HAMPSON JONES, M. D.

Filed ..... 191.....

1927 Per ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11-1-27, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-15-192?, to 11-1-192?, that I saw her alive on 10-31-192?, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chron Gastritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. P. Porter M. D.

(Address) 161 S. Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Nov 3 1927

20-UNDERTAKER, Wm H Grace & Son ADDRESS 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27021

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 3-5 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (WAWRZENIEC) VERNON MACIEWSKI

(a) RESIDENCE No. 315 South Bethel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: mak

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 2-6-27

7 AGE — Years: ~~8 months~~ | Months: 8 | Days: 25 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: ALEXANDER-MARCUS SKI

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Wojtalewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: [illegible] (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov-1- 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept-24, 1927, to Nov 1 5, 1927, that I last saw him alive on November 1, 1927, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) D. C. Kaufman M. D.

11/1, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: 11/3 1927

UNDERTAKER: William Fralkone 14 — ADDRESS: 1618 Eastern Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27022

CERTIFICATE OF DEATH.

E 27022

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: No. Franklin D. Hospital (Ward)

2-FULL NAME Lewis Pettigrew

(a) RESIDENCE NO. Washington D.C. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: About 32 | Months: - | Days: - | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Unknown

PARENTS

10 NAME OF FATHER: "

11 BIRTHPLACE OF FATHER (city or town): "

(State or country)

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): "

14 Informant: S.W. Police Sta

(Address): City

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year): Oct 23rd 192 7

17 I HEREBY CERTIFY that I viewed the remains described above, held an Investigation thereon and from the evidence obtained by said Investigation find that said deceased came to death on the day stated above.

(Autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Shot through left lung by Policeman Shot Died Instantaneously Hemorrhage at once

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Fenton M. D.

Oct 24th 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND
CHIEF MORGUE

Spec.—1-12-23—M&T—500 Bks.

E 27023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

56 E 27023

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Ausquith St. ST., 9-18 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby boy Anderson

(a) RESIDENCE NO. 1906 Ausquith St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: ww

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): Oct 7, 1927

7 AGE — Years | Months | Days: 24 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: no

(b) General nature of industry, business, or establishment in which employed (or employer): no

(c) Name of employer: no

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Annie Harrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant
(Address)

15 Filed ..... , 19 1865 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1927, to Oct 30, 1927, that I last saw h- alive on Oct 30, 1927 and that death occurred, on the date stated above, at 6 a m

The CAUSE OF DEATH* was as follows:

Marasmus Rickets and Inanition

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) G. D. Hall, M. D.

, 19 (Address) 726 E 23 St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL, 19

20 UNDERTAKER — ADDRESS

NOV 1 1927

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27024

CERTIFICATE OF DEATH

E 27024

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4637 Reisterstown Road Ward) 27-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella H. Arnold

(a) RESIDENCE NO. 4637 Reisterstown Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter G. Arnold

6 DATE OF BIRTH (month, day, and year) October, 21 1850

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	77	xx	7 9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Snow Hill

(State or country) Maryland

PARENTS

10 NAME OF FATHER James F. Truit

11 BIRTHPLACE OF FATHER (City or town) Snow Hill

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Miss Hayward

13 BIRTHPLACE OF MOTHER (city or town) Snow Hill

(State or country) Maryland

14 Informant Miss Mary V. Arnold

(Address) 4637 Reisterstown Rd

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October, 30th. 19 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 22d, 1927, to Oct 29, 1927, that I last saw h[illegible] alive on Oct 29, 1927, and that death occurred, on the date stated above, at 10.10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia Seconsia

(duration) Indef yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

11/1. 1927 (Address) 850 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn Cemetery.	Nov. 2nd 1927

20 UNDERTAKER [illegible] Cook ADDRESS [illegible] N. Dallas.

CAUTION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state NAME OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 27025

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St. 20-47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Weis

(a) RESIDENCE NO. German Aged Home ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 23, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Schneider

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Kiehling

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14

Informant

(Address) Baltimore & Payson Sts

15

Filed . 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31-27 19

17

I HEREBY CERTIFY, That I attended deceased from 10-31-27 . 19 . to 10-31-27 . 19 ,

that I last saw her alive on 10-31-27 . 19 ,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Strangulated Gangrenous Femoral Hernia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10-31-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Cecil M. Hall , M. D.

11/1/27 , 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: 11/3/27

20 UNDERTAKER: Ralph Cook

ADDRESS: 1003 W. Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E. 27026

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 27026

54

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS 10-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Ryan

(a) RESIDENCE NO. 4901 Eastern Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Tender

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston

(State or country) Md.

PARENTS

10 NAME OF FATHER Timothy Ryan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant

(Address) Records

15 Filed ..... 19 .....

Registrar

BALTIMORE CITY HOS

C. HAMPSON JONES, M. D.

NOV 1 1927

Per ..... ATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct 29th 1927

17 I HEREBY CERTIFY, That I attended deceased from

June 8, 1927, to Oct 27, 1927

that I last saw him alive on Oct 29, 1927,

and that death occurred, on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra

Bronchopneumonia

(duration) yrs. 2 mos ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gen'l appearance

(Signed) C. Hampson Jones, M. D.

19 (Address) BALTIMORE CITY HOS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross Cem.

Date of Burial 11/2 1927

20 UNDERTAKER J. J. Moran

ADDRESS 1000 E. Baltimore

NAME PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

White
Chas. Bromley

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27027

CERTIFICATE OF DEATH.

E 27027

10-14-52

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1238 Asquith St. WARD)

2-FULL NAME Rudolph C. Von Munchow Jr

(a) RESIDENCE No. 1238 Asquith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Susie Von Munchow

6 DATE OF BIRTH (month, day, and year) May 7-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	47	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Cutter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimor

PARENTS

10 NAME OF FATHER R.C Von Munchow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Whetsick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimor

14 Informant Mary Von Munchow
(Address) 1238 Asquith St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1927

17

I HEREBY CERTIFY, That I attended deceased from Mar 29, 1927, to Oct 29, 1927, that I last saw h alive on Oct 28, 1927, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Chr. Arthritis Deformans

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Tumor Nervous

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm M White, M. D.

10/31/27 19 (Address) 1800 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimor County — DATE OF BURIAL Nov 2 1927

20 UNDERTAKER Wm Cook — ADDRESS 532 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27028

CERTIFICATE OF DEATH

E 27028

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1332 N Gilmor St (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie E Young

(a) RESIDENCE NO. 1332 N Gilmor St Ward. Waldorf St Mary's Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm J Young

6 DATE OF BIRTH (month, day, and year): Aug 14th 1877

7 AGE — Years: 50 Months: 2 Days: 17 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: St Marys Co

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Adam Bondi

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Young (Address) 1332 N Gilmor St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Nov 1. 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1927, to Nov 1, 1927, that I last saw her alive on Oct 31, 1927, and that death occurred, on the date stated above, at 1.30a m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(duration) ✓ yrs. ✓ mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ✓ yrs. ✓ mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) Geo E Shannon, M. D.

11/1, 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additionni space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: St Joseph Cath Date of Burial Nov 3rd 27

20 UNDERTAKER: Gaines & Wright ADDRESS 1364 N Carey

C. THOMPSON JONES, M. D.

NOV 1 1927

Registrar

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27029

CERTIFICATE OF DEATH.

168 E 27029

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Richard E. Robertson St. [illegible] Ward)

2-FULL NAME Fred 307 N. Charles.

(a) RESIDENCE NO. 214 Md. Ave. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years: 3-0 yrs about Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Manager
(b) General nature of industry, business, or establishment in which employed (or employer): Shoe Store
(c) Name of employer

9 BIRTHPLACE (city or town): ?
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed_____ 19____ C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Found dead Oct. 31-27. Dec 29/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) [signature] M. D.
(Coroner)
Oct 29 1927 (Address) 1629 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Waynesboro Pa Date of Burial 11/1 27

20 UNDERTAKER: Geo. A. Templeton & Sons ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27030

CERTIFICATE OF DEATH.

118-001

E 27030

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE; (No. Maryland General Hospital 1124 Ward)

2-FULL NAME Margaret Garfield Emory

(a) RESIDENCE NO. 851 Park Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addison Emory

6 DATE OF BIRTH (month, day, and year) November 27-1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Lisbon, Md

(State or country) _____

PARENTS

10 NAME OF FATHER Samuel Garfield

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER Elizabeth H. Owings

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Md

14 Informant Guy T Garfield

(Address) 380 W Greenway.

15 Filed _____, 19 _____ _____ Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy and inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. T. Kenney M. D.

(Coroner)

1927 (Address) 25 E Eccleston Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Centreville, Md — Date of Burial Nov 2 1927

20 UNDERTAKER W. J. Dickinson & Sons — ADDRESS 1-14 Pa Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27031

90 E 27031

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2209 Allendale Road St. 15-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alison Forsyth Swanston,

(a) RESIDENCE NO. 2209 Allendale Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? 5 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Wpdow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Swanston,

6 DATE OF BIRTH (month, day, and year) December 21. 1837

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	89	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Scotland

PARENTS

10 NAME OF FATHER John Purves,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Ellanor Forsyth,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland.

14 Informant J. S. Cruikshanks

(Address) 2209 Allendale Rd

15 Filed NOV 1 1927, 19

C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 1 - 1927 19

17 I HEREBY CERTIFY, That I attended deceased from about 1 year 9 mo, 18..., to Nov. 1, 1927.

that I last saw h-- alive on Oct 31, 1927.

and that death occurred, on the date stated above, at 3 1/2 p.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) about 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross appearance

(Signed) L. L. Thewall, M. D.

Nov. 1, 1927 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Britain Conn

Date of Burial NOV 3 - 1927 19

20 UNDERTAKER Geo. W. Little

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of the above form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27032

CERTIFICATE OF DEATH.

166 E 27032

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St. 26-41 Ward)

2-FULL NAME Antonette Connors

(a) RESIDENCE NO. 300 Valley Street Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 22 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Fredric Paramuk

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Paramuk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant

(Address) Undertaker John Grabbank 423 S Broadway

15 Filed ....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hydrochloride Mercury poisoning

Since Oct 26 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

(Signed) W J Riley M. D.

(Coroner)

Oct Nov 1 — , 1927 (Address) 1637 Broadway

*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Russian Jewish Cem. Date of Burial 11/2 1927

20 UNDERTAKER: John Grabbank ADDRESS 423 S Broadway

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27033

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 S. East Ave St. V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Nelson

(a) RESIDENCE NO. 10 S. East Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Nelson

6 DATE OF BIRTH (month, day, and year): Nov. 5. 1858

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
68	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Capt. Dredging Machine

(b) General nature of industry, business, or establishment in which employed (or employer): Sand & Gravel

(c) Name of employer: Warner Bros,

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Chas. H. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Elizabeth Lehmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William W. Nelson

(Address): 5042 Kreeger St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1927, to Oct 30, 1927, that I last saw h— alive on Oct 30, 1927, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Cancer Recti —

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary): General Condition

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Frank E Bruner, M. D.

, 19 (Address) 1250 Bolton —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery

DATE OF BURIAL: Nov. 2 1927

20 UNDERTAKER: Henry Sonder & Sons Inc

ADDRESS: 1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1927 G. HAMPSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27034

CERTIFICATE OF DEATH

11-001

E 27034

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2625 Wilkens Ave., St. 20-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Merie Hrastovecz

(a) RESIDENCE NO. 2625 Wilkens Ave., St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Steven Hrastovecz

6 DATE OF BIRTH (month, day, and year) ? ? Unknown 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	46	7	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Hungary

PARENTS

10 NAME OF FATHER Louis Somogyi
11 BIRTHPLACE OF FATHER (City or town)
(State or country) Hungary
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Steven Hrastovecz
(Address) 2625 Wilkens Ave.

15 Filed ..., 19.. C. HAMILTON JONES, M. D. Registrar

NOV 2 - 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1927, to Oct 30, 1927, that I last saw her alive on Oct 30, 1927, and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
Myocarditis. Influenza

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical

(Signed) Norbert K Hirsch, M. D.
Oct 31. 1927 (Address) 215 1 Walbrook ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 11/3/27

20 UNDERTAKER Harry A Weitzke — ADDRESS 1531 W Lombard

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27035

CERTIFICATE OF DEATH

100-001

E 27035

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2210 Penrose Ave., St. 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice B. Schmidt.

(a) RESIDENCE NO. 2210 Penrose Ave. St. Ward

(Usual place of abode) Life

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	I	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child. gd
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Irvin W. Schmidt

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Shilpey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Irvin W Schmidt
(Address) 2210 Penrose Ave.,

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1927, to Oct 30, 1927.

that I last saw her alive on Oct 29, 1927.

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) acute tympanitis

degeneration (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dr Truckel, M. D.

Oct 31, 1927 (Address) 290 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

Date of Burial 11/2/27

20 UNDERTAKER Harry A Wetzke

ADDRESS 1531 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27036

CERTIFICATE OF DEATH.

129 E 27036

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 504 N. Chester ST., 24 (WARD)

2-FULL NAME Lisetta Abendschein

(a) RESIDENCE NO. 504 N. Chester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Andrew S. Abendschein

6 DATE OF BIRTH (month, day, and year): July 6th 1866.

7 AGE: Years 61 Months 3 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Kaiser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Andrew S. Abendschein (Address) 504 N. Chester St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1927

17

I HEREBY CERTIFY, That I attended deceased from October 27, 1927, to Oct 30, 1927, that I last saw her alive on Oct 30, 1927, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular-renal

Chr. Myocarditis

arterial Hypertension & chr. nephritis.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Pulmonary oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy exam.

(Signed) Louis F. Krumrau, M. D.

, 19 (Address) 722 N. Howard ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Nov 2 1927

20 UNDERTAKER: Mrs C. Miller & Son — ADDRESS 2534 Jefferson ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27037 — 1-PLACE OF DEATH

129

E 27037 — REGISTERED NO.

City of BALTIMORE: (No. 42 N Bond St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Carroll

(a) RESIDENCE NO. 42 N Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude Carroll

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: 55 Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wagon Driver

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Bloomyer Bros

9 BIRTHPLACE (city or town):

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14 Informant: Gertrude Carroll

(Address) 42 N Bond St

15 Filed....., 19.. C. HARRY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ... find that said deceased came to death ... on the day stated above.

The CAUSE OF DEATH was as follows:*

Chr Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

Attended 31/2 hrs. (Corrected) (Address) M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury — Date of Burial: Nov-2 1925

20 UNDERTAKER: John W Henderson — ADDRESS 1502 E Monument

tion should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

NOV 2 1925 C. HARRY JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

206 8 & 2 E 27038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 27038

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. JOHNS HOPKINS HOSPITAL ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Cohen

(a) RESIDENCE NO. 324 E. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Relative JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1927, to October 1, 1927, that I last saw her alive on October 1, 1927, and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.
Hypertrophy, mitral
stenosis, malignant

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Edward [illegible], M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First German Lutheran	10/7/27
20 UNDERTAKER Joseph Abrams	ADDRESS 224 Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Geo A Bishop

207817

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27039

CERTIFICATE OF DEATH.

127 E 27039

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 6-10 WARD)

2-FULL NAME George A Bishop

(a) RESIDENCE NO. 2 No Bradford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jessie A Bishop

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE: Years 39; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer City Fire Dept.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Bishop

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Kate Seegers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jessie JOHNS HOPKINS HOSPITAL (Address)

15 Filed NOV 2 - 1927 Per C HAMILTON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1927, to Oct. 31, 1927, that I last saw him alive on Oct. 31, 1927, and that death occurred, on the date stated above, at 3:25 A. m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis, Hypertension; Myoc. Insufficiency - arteriosclerosis - 2'ry anaemia

(duration) ? 18 months. yrs. mos ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Chas. Hamilton Johnston, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 11/2/27

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27040

CERTIFICATE OF DEATH.

90 E 27040

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 427 Gilmor St. 16-27 Ward)

2-FULL NAME Martha A C Gates

(a) RESIDENCE NO. 427 Gilmor St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town): Hertford

(State or country): N. C.

PARENTS

10 NAME OF FATHER: Silver Felton

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country): N C

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country): Unknown

14 Informant: Sarah O. V. Taylor

(Address) 729 E Capitol St. Washington D.C.

15 Filed_____, 19_____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 1 ds.

(Signed) C B Yates M. D.

(Coroner)

11/2/19 (Address) 143 W Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial Nov 5 1927

20 UNDERTAKER: Sumner Stansbury & Kidde ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27041 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. E 27041

1-PLACE OF DEATH Baltimore City Hospitals. REGISTERED NO. 38

CITY OF BALTIMORE: (No. Balto md ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Neena Chase

(a) RESIDENCE No. 531 Lambert St ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Samuel Chase

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: 49 (Years / Months / Days; If LESS than 1 day, ... hrs. or ... min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ...037

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Nelson Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Laura Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Balto City Hospts (Address) Balto Md

15 Filed NOV 2 1927 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-30 1927

17 I HEREBY CERTIFY, That I attended deceased from 4-10-, 1927 to 10-30-, 1927, that I last saw her alive on 10-30-, 1927 and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Lueitic Infection

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Serological & Clinical

(Signed) Harry Greenstein, M. D.

10/31 1927 Address 1 Plume Ct Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Nov 3 1927

20 UNDERTAKER: John H. Toadvine — ADDRESS

NOV 2 1927 H. HAMILTON, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27042

CERTIFICATE OF DEATH.

REGISTERED NO. E 27042

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] Front near Eutaw St., 5[illegible] Ward)

2-FULL NAME Wm Stokes

(a) RESIDENCE NO. 1003 E. Monument St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Marr

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 35 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lunch room

(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va.

PARENTS

10 NAME OF FATHER: Ed Stokes

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Sus. Hogan.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): [illegible]

14 Informant: Sus. Stokes

(Address): 1003 Monument

15 Filed [illegible] 19[illegible] [illegible] M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 31 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest and (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Gun shot wound of chest Homicide

(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

CONTRIBUTORY (Secondary) [illegible] Sudden

(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

(Signed) [illegible] (Coroner) [illegible] M. D.

Nov 2, 1927 (Address) 1627 Bruns

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death [illegible] yrs. [illegible] mos. [illegible] ds. In the State [illegible] yrs. [illegible] mos. [illegible] ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pilursburg Va Date of Burial: Nov 2 1927

UNDERTAKER: Robert A. Williams ADDRESS: 1515 W. Fayette St

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 27043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 ✓ E 27043

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 13-54 Ward)

2-FULL NAME Isaac C. Weiller

(a) RESIDENCE NO. 2318 Mt. Royal Terrace St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Weiller

6 DATE OF BIRTH (month, day, and year) Aug. 11, 1854.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Goods.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.

(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Weiller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Hannah Steiner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. Charles I. Weiller

(Address) Naylor Lane. (Pikesville, Md.)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31/ 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acc Fall down Entire Shaft.

Fracture of Skull

(Duration) ..... yrs. Instant ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. Instant mos. ds.

Signed) C. Statz M. D.

(Coroner)

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., 1 ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2318 Mt. Royal Terrace

19 PLACE OF BURIAL, ~~CREMATION~~ REMOVAL Date of Burial

Baltimore Hebrew Cem. 11/2/ 1927

20 UNDERTAKER ADDRESS

Harid Sondheim 11-20 W 20th Royal Ave.

OCT 2 - 1927 C. HAMPSON JONES, M.D.

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27044 ✓ E 27044

CERTIFICATE OF DEATH.

161-002

1-PLACE OF DEATH

City of BALTIMORE: (No. 1103 S Sharp St. 2331 Ward)

Registered No.

2-FULL NAME.... Baby Girl Johnson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1103 S. Sharp Street St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black.

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 26, 1927

7-AGE. ....yrs. ....mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.... gd

(b) General nature of industry, business, or establishment in which employed (or employer)....

(c) Name of employer....

9-BIRTHPLACE (city or town): Balt Md. (State or Country),

PARENTS.

10-NAME OF FATHER, Joseph Henry Johnson

11-BIRTHPLACE OF FATHER (city or town) Hedgfield (State or Country), S.C.

12-MAIDEN NAME OF MOTHER, Louisa Paterson

13-BIRTHPLACE OF MOTHER (city or town) Columbia (State or Country), S.C.

14- (Informant)....

(Address)....

15- Filed ....192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 30, 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 26, 1927 to Oct 30, 1927, that I last saw her alive on Oct 30, 1927, and that death occurred, on the date stated above, at 2.00 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

....(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Increased Intra Cranial pressure.

....(Duration)....yrs....mos....ds.

18-Where was disease contracted if not at place of death?....

Did an operation precede death? No Date of....

Was there an autopsy? Yes.

What test confirmed diagnosis? Phy exam Autopsy.

(Signed) Knight Reynolds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Md

DATE OF BURIAL, ..., 19....

20-UNDERTAKER.

ADDRESS

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27045

CERTIFICATE OF DEATH.

51V

E 27045

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1032 W. Lexington St., 18th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marco Boston

(a) RESIDENCE NO. 1032 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 2, 1918

7 AGE — Years: 9 — Months: 8 — Days: 28 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Boston

11 BIRTHPLACE OF FATHER (city or town): Annapolis

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Mouton

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto. Md.

14 Informant: Hannah Boston

(Address): 227 N. Schroeder

15 Filed NOV 2 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Oct 30 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 25, 1927, to Oct 30, 1927, that I last saw h... alive on Oct 29, 1927, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary): Pulm. Oedema

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? ... Date of ... No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) 1732 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: Nov. 2 1927

20 UNDERTAKER: Mrs Kate R. Williams — ADDRESS 322 N. Schroeder St

Use ink or typewriter ribbon. Copy must be plainly written. Ages should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 2 1927

Spec.—1-12-23—M&T—500 Bks.

E 27046

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27046

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospitals ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cooper Goldman (Cooper L. Goldman)

(a) RESIDENCE No. 1519 N Regester ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? 43 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Barbara Goldman

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Steinrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Barbara Goldman

(Address) 1519 N. Regester St

15 Filed ..... 19 .....

RMM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1927, to Oct 31, 1927

that I last saw him alive on Oct 31, 1927

and that death occurred, on the date stated above, at 6.45 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Benign Prostatic Hypertrophy

(duration) Months Days.

CONTRIBUTORY (Secondary) Lemmal Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Bayne-Jones, M. D.

Nov 1, 1927 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Nov 4 1927

20 UNDERTAKER Henry Hirsch Son — ADDRESS 1316 Eager St

TION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

E 27047

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27047

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1726 N. Fulton Ave. ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Louis

(a) RESIDENCE. No. 1726 N. Fulton ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of John Louis

6 DATE OF BIRTH (month, day, and year) May 23, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New Alford Penna.

PARENTS

10 NAME OF FATHER Thos. Flemmine

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Alford, Penna.

12 MAIDEN NAME OF MOTHER Magdelene Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Alford Penna.

14 Informant Mrs. Agnes E. Gourley

(Address) 1726 N. Fulton Ave.

15 Filed . 19 Pet Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 31, 1927

17

I HEREBY CERTIFY, That I attended deceased from October 25, 1926 to October 30, 1927, that I last saw her alive on October 30, 1927, and that death occurred, on the date stated above, at six A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation.

(duration) 1 yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) None.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination.

(Signed) John D. Quinn, M. D.

19 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11-3-27.

20 UNDERTAKER Martin Fahey Sons ADDRESS Baltimore.

IT IS THE DUTY OF EVERY PERSON having knowledge of any death to report it to the Health Department. Information should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27048

100-09 27048

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2452 Druid Hill ave ST. 13-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Bell Brill

(a) RESIDENCE NO. 2452 Druid Hill ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Brill

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Julia Landy

(Address) 2452 Druid Hill ave

15 Filed ——, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2 1927

17

I HEREBY CERTIFY, That I attended deceased from October 30, 1927, to November 1, 1927, that I last saw her alive on November 1, 1927, and that death occurred, on the date stated above, at 4:9 m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robt. Isaacs, M. D.

, 19 (Address) 1852 E Balto st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt. Carmel

DATE OF BURIAL 11-7- 1927

20 UNDERTAKER Joel Levin, 1439

ADDRESS E Balto

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27019 1-FULL NAME OF DEATH

REGISTERED NO. 37019

City of BALTIMORE: (No. 1143 N. Stricker St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Biggers

(a) RESIDENCE NO. 1143 N. Stricker St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 6, 1927

7 AGE: Years 5 Months Days 25 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): (Deceased)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Robert Young

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Corrine Biggers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Robert Young.

(Address) 1143 N. Stricker St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) did that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull accidental (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fell out of bed, (duration) yrs. mos. ds.

(Signed) J. C. Weinberg M. D. (Coroner)

April 1, 1927 (Address) 2572 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery Date of Burial Nov 2 1927

20 UNDERTAKER: Thomas E. Kelson ADDRESS 1303 Presstman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

94-001

E 27050

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO. E 27050

City of BALTIMORE: (No. ~~2~~ 2012 mace St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Stephney

(a) RESIDENCE NO. 2012 mace St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widowed,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis Stephney.

6 DATE OF BIRTH (month, day, and year): Aug 6, 1860.

7 AGE: Years 67 Months 2 Days 24

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work at home.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): A.A. Co md.

PARENTS

10 NAME OF FATHER: John Brown.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): A.A. Co md,

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): md

14 Informant: Geo E W. Talbot.

(Address): 2012. mace st.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct, 31 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 29 19 27, to Oct 31st 1927, that I last saw h[illegible] alive on Oct 31 1927, and that death occurred, on the date stated above, at 1 01 P.M. xy

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 3 ds.

CONTRIBITORY (Secondary): Unknown.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Personal observation.

(Signed) Wm Conrad Bodie, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery Date of Burial NOV 3 1927

20 UNDERTAKER: Thomas E Kelson ADDRESS 1303 Pressman

OF DEATH in plain terms, so that it may be properly classified. Age should be stated EXACTLY. PHYSICIANS should state CAUSE very important. See instructions on back of certificates. Last statement of OCCUPATION

Spec.—1-12-23—M&T—500 Blks.

E 27051 HEALTH DEPARTMENT—CITY OF BALTIMORE

89 E 27051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1801 Chelsea Road (St.) 1567 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Rev) William Crumpler Boswell

(a) RESIDENCE NO. 1801 Chelsea Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roberta Fitzhugh Boswell

6 DATE OF BIRTH (month, day, and year) Oct 3-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister of Gospel

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Orange Va

PARENTS

10 NAME OF FATHER Hay Boswell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Roberta F. Boswell

(Address) 1801 Chelsea Road

15 Filed , 19 R H H Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12th 1927

17

I HEREBY CERTIFY, That I attended deceased from October 22, 1927, to Nov 12, 1927,

that I last saw h[illegible] alive on Nov 12 1927,

and that death occurred, on the date stated above, at 8 15 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hemdon Fairfax Co Va

DATE OF BURIAL Nov 3rd 1927

20 UNDERTAKER Pettiard & Lee

ADDRESS 1723 W Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27052

CERTIFICATE OF DEATH.

E 27052

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2037 E 31st St. 9th Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida L. Eggleston

(a) RESIDENCE NO. 2032 E. 31 St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. N. Eggleston

6 DATE OF BIRTH (month, day, and year): Nov 12 - 1860

7 AGE: Years 67 | Months 11 | Days 19 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Mfr

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Richard F. Coates

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Lee

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Mrs N. Eggleston

(Address) 2032 E. 31st

15 Filed ..... 19..... Per ..... Registrar

C. HAMILTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 31 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1927, to Oct. 31, 1927, that I last saw her alive on Oct 31, 1927, and that death occurred, on the date stated above, at 11.55 P.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Diabetes

(duration) 20 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. L. Zimmerman M. D.

Oct 31 1927 (Address) 983 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial Nov 3 1927

20 UNDERTAKER: Robt J. Sinnott & Son ADDRESS 1xx Pratt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27053

CERTIFICATE OF DEATH.

84 E 27053

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3947 Clover Hill Road ST. 12-49 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Lorimier Hopkins

(a) RESIDENCE No.... 3947 Clover Hill Road ST. WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 7 mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Blanche Patterson

6 DATE OF BIRTH (month, day, and year) July 8, 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Waverly Iowa

PARENTS

10 NAME OF FATHER ------ Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not obtainable

12 MAIDEN NAME OF MOTHER ---- Kidd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not obtainable

14 Informant Mrs. Blanche Hopkins
(Address) 3947 Clover Hill Road

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31st 1927

17 I HEREBY CERTIFY, That I attended deceased from August. 1927. to Oct. 31st. 1927. that I last saw him alive on Oct. 30th. 1927. and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Right Cerebral Thrombosis.

(duration) -- yrs. -- mos. -- ds.

CONTRIBUTORY (Secondary) Duration unknown yrs. mos.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No. Date of April 11th/1927

Was there an autopsy? No.

What test confirmed diagnosis? As stated.

(Signed) Walter Wirt M. D.

Oct 2, 1927 (Address) 3005 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL 11/2 19 27

20 UNDERTAKER Henry U. Myers & Son — ADDRESS 805 N. Calvert

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 27054

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 139 ✓ E 27054

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University of Maryland Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel Scott

(a) RESIDENCE NO. Hurlock Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ? ? 1900

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Harrison Holley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lindsey Butler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 1st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

After Fibroid

Post Partum Shock

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) G. E. Bladen M. D.

(Coroner)

(Address) 1436 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hurlock Md Date of Burial Nov 2 1927

20 UNDERTAKER H. J. Tucker & Sons ADDRESS Hurlock

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 27055

CERTIFICATE OF DEATH.

E 27055

188-093

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Hospital St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Lombardi

(a) RESIDENCE NO. 1010 Stiles St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23/1919

7 AGE

Years	Months	Days	IF LESS than 1 day .... hrs. or .... min.
8	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Anthony Lombardi

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Angelina Angiuano

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant

(Address) 311 S Eden St

15 Filed 19

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Intracranial hemorrhage

Run over by Taxi cab near 1007 E. Pratt ST.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. W. Callon M. D.

(Coroner)

11/1/27 (Address) 509 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial Nov. 2. 1927.

20 UNDERTAKER Waddell & Lippel ADDRESS 311 S Eden St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 2 1927 C. Harrison Jones M.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27056

CERTIFICATE OF DEATH.

90 E 27056

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 315 S Bond ST., 34 WARD)

2-FULL NAME Brigid Curran

(a) RESIDENCE NO. 315 S Bond ST., ... WARD ...

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 80 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of ———

6 DATE OF BIRTH (month, day, and year): May 15 1830

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
97	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Lacy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Frank Curran (Address) 315 S Bond St

15 Filed ... , 19 ... R.H.H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 — , 1927, to Oct 31 — , 1927, that I last saw h— alive on Oct 31 , 1927, and that death occurred, on the date stated above, at 10:45 0 m.

The CAUSE OF DEATH* was as follows:

Senile - Cardio - Vascular Dis

(duration) 3 — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) General Debility —

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. O'Brien, M. D.

, 19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — DATE OF BURIAL: Nov 3 1927

20 UNDERTAKER: Windell Oldfield & Son — ADDRESS: 375 Mun

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 27057

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+69 E 27057

REGISTERED NO. .....

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. 4-30 St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Welch

(a) RESIDENCE NO. Savage, Md St. ..... Ward Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. 1 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE Years: 11 Months: ..... Days: .....

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town): .....

(State or country) Maryland

PARENTS

10 NAME OF FATHER Eugene Welch

11 BIRTHPLACE OF FATHER (City or town): .....

(State or country) Md

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town): .....

(State or country)

14 Informant Eugene Welch

(Address) Savage Md

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November, 2 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/1/27, 19..., to 11/2/, 19 27,

that I last saw ~~him~~ alive on 11/2, 19 27,

and that death occurred, on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:

Extensive subperitoneal hemorrhage and hemorrhage into left pleural cavity, probably due to hemophilia.

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? .....

Did an operation precede death? Yes Date of 11/1/27

Was there an autopsy? Yes Clinical Diagnosis

What test confirmed diagnosis? Clinical

(Signed) C. W. Drake M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cemetary — Date of Burial: Nov 4th 1927

20 UNDERTAKER: Edward R Fickus — ADDRESS: Laurel Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27058

CERTIFICATE OF DEATH.

66 E 27058

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Declared dead at St. Joseph Hospital St. 27-44 Ward)

2-FULL NAME ~~Noah Coleman~~

(a) RESIDENCE NO. 4010 Elgrode Ave St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12/1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer W

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Coleman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Coleman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Geo. Ruth

(Address) 1735 Harford Ave

15 Filed....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism- (found on lot 20th & Aisquith St)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. C. Pollitt M. D.

(Coroner)

11/2/27 (Address) 503 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL George Ruth 1735 Harford Ave Date of Burial 11 1927

20 UNDERTAKER Loudon Park Cemetery Harford Ave ADDRESS

If space is not sufficient to answer questions fully, use blank below. Be sure to give number of question. Use this space also for any additional information which may be required by law or which you may deem very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 27059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62-11-22

129 E 27059

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4610 Elsrod ave St. Lauraine Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah R. Coleman

(a) RESIDENCE NO. 4610 Elsrod ave St. Lauraine Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~1 year~~ mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, ~~Widowed~~, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H Coleman.

6 DATE OF BIRTH (month, day, and year) Nov 8. 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
62		11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Charles Coleman

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Mary Coleman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Charles H. Coleman

(Address) 4610 Elsrode ave Lauraine

15 Filed Nov 3 1927 C. HAMPSON JONES, M.D. Registrar

RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 – 1927

17 I HEREBY CERTIFY, That I attended deceased from May 1 – 1927 to October 31 1927

that I last saw her alive on " " 1927

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Tenby M. D.

Nov. 2 – 1927 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Nov 3 1927

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hanford Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27060

CERTIFICATE OF DEATH

90 E 27060

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Cecil Apt N. Eutaw St 1927 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mackall

(a) RESIDENCE NO. Cecil Apt Eutaw St Near Dolphin St Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced. (write the word): Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of: Ida Bowie Mackall

6 DATE OF BIRTH (month, day, and year): Sept 26 1846

7 AGE: Years 81 Months 1 Days 5

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: former President

(b) General nature of industry, business, or establishment in which employed (or employer): Fairmount Coal Co

(c) Name of employer

9 BIRTHPLACE (city or town): Georgetown

(State or country): D. C.

PARENTS

10 NAME OF FATHER: R. L. Mackall

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Georgetown D. C.

12 MAIDEN NAME OF MOTHER: Anna Bolt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Georgetown D. C.

14 Informant: Ida Bowie

(Address): Cecil Apt & Eutaw St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1927, to Nov. 1st, 1927, that I last saw him alive on November 1st, 1927, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Shearer, M. D.

Nov. 3, 1927 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — Date of Burial: Nov 3rd 1927

20 UNDERTAKER: Henry W Jenkins Sons Co — ADDRESS: Oakland & Mt Holly

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27061

CERTIFICATE OF DEATH.

E 27061

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Reisterstown Rd & Gabriel Ave St., 90 Ward)

2-FULL NAME Walter E. Schroeder

(a) RESIDENCE NO. 5249 Linden Heights Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Schroeder

6 DATE OF BIRTH (month, day, and year) July 11, 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Produce Dealer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Schroeder

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Jennie Fogle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Walter Schroeder

(Address) 28 W. Lanvale St.

15 Filed ..... 19.. ..... Registrar

NPH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrison M. D.

(Coroner)

11/2, 1927 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery Date of Burial Nov. 3, 1927

20 UNDERTAKER E. Leroy Stiffler ADDRESS 125 E. North ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-801

E 27062

CERTIFICATE OF DEATH.

E 27062

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 E. Eager ST. 11-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Jones

(a) RESIDENCE NO. 11 E. Eager ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dessie S. M. Griffith

6 DATE OF BIRTH (month, day, and year): Dec. 4, 1869

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: President

(b) General nature of industry, business, or establishment in which employed (or employer): Eastern Rolling

(c) Name of employer: Mill Company

9 BIRTHPLACE (city or town) (State or country): South Wales

PARENTS

10 NAME OF FATHER: David Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Wales

12 MAIDEN NAME OF MOTHER: Sarah Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): South Wales

14 Informant (Address): Lewis J. Jones, Preston Apartments

15 Filed NOV 3 1927, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Tues. Oct 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 26 &, 1927, to Tues. Oct 25, 1927, that I last saw him alive on Tues. Oct 25, 1927, and that death occurred, on the date stated above, at 11.09 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, Acute

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary): none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. A. Chatard, M. D.

Nov. 1. 1927 (Address) 300 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: 11/3 19 27

20 UNDERTAKER: Henry W. Weaver & Son

ADDRESS: 805 N Calvert

FULL INFORMATION IS very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

Gibson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27063

CERTIFICATE OF DEATH

49 E 27063

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE. (No. Md. Genl Hosp. St. 8-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Gibson

(a) RESIDENCE NO. 1413 E. Eddle St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. H. Gibson

6 DATE OF BIRTH (month, day, and year) Dec 15, 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	72	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Jno J. Ferguson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Blizzard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carroll Co Md

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-24, 1927, to 11-1, 1927,

that I last saw h.. alive on 11-1, 1927,

and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Head of Pancreas

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from intestines

acute intestinal obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? Yes Date of 10/29/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A. Andrews, M. D.

, 19 (Address) Md Genl Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	Nov 4 1927
20 UNDERTAKER George N. Junkin	ADDRESS 1315 E. Eager St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 27064

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27064

CERTIFICATE OF DEATH

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. Bd. Gen. Hosp. 24-35 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Shaddock

(a) RESIDENCE NO. 1416 Hull St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2, 1917

7 AGE	Years	Months	Days
	10	6	0

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Newport News Va

(State or country)

PARENTS

10 NAME OF FATHER Lewis Shaddock

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Irene Stafford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 2, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 19 27, to Nov. 2, 19 27,

that I last saw him alive on Nov. 2, 19 27,

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Chorea

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 3 yrs. mos ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) Bd. Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill.

Date of Burial Nov 5. 1927

20 UNDERTAKER Chas. H. Stevens

ADDRESS 1501 E Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27065

I-PLACE OF DEATH

CERTIFICATE OF DEATH.

X 124 E 27065

REGISTERED NO.

City of BALTIMORE: (No. 1229 N. Curley St St., 8-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lowery A. Waters

(a) RESIDENCE NO. 13th St. N.W. Wash. St. D.C. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. / ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B. Waters

6 DATE OF BIRTH (month, day, and year) May 20/1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dist. Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer C & P Telephone Co

9 BIRTHPLACE (city or town)

(State or country) Wash. D.C.

PARENTS

10 NAME OF FATHER C. J. Waters

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Wash. D.C.

12 MAIDEN NAME OF MOTHER Sarah M. Shae

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Wash. D.C.

14 Informant J.F.Conrad

(Address) Washington, D.C.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Probably Myocardial Failure (Recovering from an attack of Cholecystitis)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. E. Collins M. D.

(Coroner)

11/3/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. Date of Burial Nov 5 1927.

20 UNDERTAKER M E Gosson ADDRESS 841 N. 31st

OF DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27066

CERTIFICATE OF DEATH.

89 E 27066

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Union Memorial Hosp. 12-50 (Ward)

2-FULL NAME Ephraim Frank

(a) RESIDENCE No. 3214 Greenmount Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva Frank

6 DATE OF BIRTH (month, day, and year): March 10 - 1880

7 AGE: Years 47 Months 7 Days 23 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Russia

PARENTS

10 NAME OF FATHER: Hyman Frank

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Russia

12 MAIDEN NAME OF MOTHER: Dinkin

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Russia

14 Informant: Eva Frank

(Address) 3214 Greenmount Ave

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 22 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

11/2, 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herm Rm Date of Burial 11/3 19 27

20 UNDERTAKER: Jack Levin ADDRESS 1439 E Balt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27067 E 27067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2606 Lehmann ST. 20-69 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Wuestling

(a) RESIDENCE NO. 2606 Lehmann ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 66 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Chas Wuestling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Welzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hannah N. Sauder
(Address) 607 Bayard Ave

15 Filed ....., 19 .... RAP Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 Nov 1927

17 I HEREBY CERTIFY, That I attended deceased from 11 Oct, 1927, to 1 Nov, 1927,
that I last saw her alive on 1 Nov, 1927
and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) H Vincent Hooper, M. D.

, 19 (Address) 2360 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gordon-Park Cemetery — DATE OF BURIAL Nov 3 19 27

20 UNDERTAKER F. D. Heyfield — ADDRESS 1850 W. Baltimore St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27068 — 1869 — 168 E 27068

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2607 N. Fairmount Place (Ward)

2-FULL NAME Ferdinand Feuchtner

(a) RESIDENCE NO. 2607 N. Fairmount ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18 — 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	58	— 13		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town)

(State or country) Hungary

PARENTS

10 NAME OF FATHER Franz Feuchtner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Hungary

12 MAIDEN NAME OF MOTHER Paulina Dorwschniak

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Hungary

14 Informant Irene Clark

(Address) Edgewood, Md

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest

and Autopsy

(Inquest, Autopsy or Inquiry.)

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Strangulation
also shot self in head
Body found

CONTRIBUTORY (Secondary)

(Signed) Thos. J. Norton M. D.
(Coroner)

Nov 2nd 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial Nov 3rd 1927

20 UNDERTAKER F. D. Pfeffer ADDRESS 850 N. Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 27069

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 Ashland Ave. ST. 10-14 WARD)

2-FULL NAME Marie Hurt

(a) RESIDENCE No. 823 Ashland ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Spencer Hurt.

6 DATE OF BIRTH (month, day, and year) Mar. 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salisbury Md.

PARENTS

10 NAME OF FATHER George Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Spencer Hurt

(Address) 823 Ashland ave

15 Filed ____, 19____ Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Nov 2, 1927, that I last saw h alive on Nov 1, 1927 and that death occurred, on the date stated above, at 5-15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T B Fletcher M. D.

11/2, 1927 (Address) 1725 Ashland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenbury Va DATE OF BURIAL Nov 3 1927

20 UNDERTAKER Mrs. R.G. Elliott ADDRESS 1725 Ashland Ave

Instructions on back of certificates. Specific information. See

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27070

CERTIFICATE OF DEATH.

X137 E 27070

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No. 25-72 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Laura La Motte

(a) RESIDENCE NO. 19 W Broadway Red Lion Pa. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marcus La Motte

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 42 Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) New Market (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Wilson ~~not given~~

11 BIRTHPLACE OF FATHER (city or town) (State or country) not given

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Marcus La Motte (Address) 19 W Broadway Red Lion

15 Filed ..... 19 ..... Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3 — 1927

17

I HEREBY CERTIFY, That I attended deceased from 9-21, 1927, to 11-3, 1927, that I last saw her alive on 11-3, 1927, and that death occurred, on the date stated above, at 6 45 a m.

The CAUSE OF DEATH* was as follows:

1 Infected Ovarian Cyst with Localized Peritonitis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Generalized Septicaemia — Pyelitis & Terminal Myocardial Insufficiency (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 9-24-27

Was there an autopsy? yes — 10-3-27.

What test confirmed diagnosis? Clinical & Surgical-autopsy

(Signed) C. J. Knapp, M. D.

10-3, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Red Lion Cemetery York Co. Pa. Date of Burial 11/5 1927

20 UNDERTAKER E. B. Bury John A. Bury ADDRESS Red Lion Pa. 115 Lightner

OCT 3 1927 CORONER

Carefully classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 27071

HEALTH DEPARTMENT—CITY OF BALTIMORE

1401 Hanover St 90

E 27071

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Lorring Coffee Co. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Hufnagel

(a) RESIDENCE NO. 819 S Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE: Years 64 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Loring Coffee House

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Balthasar Hufnagel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Ruppert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Barbara Regan

(Address) 3713 E Fairmount Ave

15 Filed....., 19.... Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

Nov 2 27 (Signed) G E Radcliff (Coroner) M. D.

19 (Address) 1433 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery Date of Burial: Nov 4 1927

20 UNDERTAKER: Wm C Miller & Son ADDRESS: 2334 Jefferson

Use typewriter if possible. Fill in all blanks. Be sure that you have properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27072 E 27072

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 Lambert St. ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Core

(a) RESIDENCE NO. 532 Lambert St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Core

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
38	-	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER ~~Core~~ Core

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER ~~Mary~~ Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Josephine Core

(Address) 532 Lambert St

15 Filed ..., 19 ..., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1927 to Nov 1, 1927.

that I last saw ~~him~~ alive on Nov 1, 1927

and that death occurred, on the date stated above, at 4 A. m

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos 4- ds.

CONTRIBUTORY (Secondary) Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Thos J Woolley Jr. M. D.

11/2 1927 (Address) 1203 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Addor N C.	Nov 3 1927

20 UNDERTAKER Durant Carson? ADDRESS Co me

NOV 3 - 1927

—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27073

CERTIFICATE OF DEATH.

66 E 27073

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 GreenMount Av. St. 10-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Kammer

(a) RESIDENCE No. 920 GreenMount Av. ST., WARD Resident.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? 60 yrs. 10 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie Kammer

6 DATE OF BIRTH (month, day, and year) Dec-29-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer) Bakery
(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Kammer

11 BIRTHPLACE OF FATHER (city or town) ? ?
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Newber

13 BIRTHPLACE OF MOTHER (city or town) ? ?
(State or country) Germany

14 Informant Dr. C. W. Kammer, (brother)
(Address) 2133 Maryland Av., City.

15 Filed NOV 3 - 1927, 192 C. HAMPTON MOALES, Registrar
By RMH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. J. Riley, M. D.
(Coroner)

Nov. 2, 192 7 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ---- yrs., ---- mos., ---- ds. In the State ---- yrs., ---- mos., ---- ds.

Where was disease contracted, if not at place of death? ----

Former or usual residence ----

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov-3-27 192

20 UNDERTAKER WILLIAM P. WOODEN COMPANY, Successors ADDRESS 1128 N. Howard St.

Spec.–7-17-26—A Co.—200 Bks.

E 27074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 27074

REGISTERED NO. 12-50

1-PLACE OF DEATH

City of BALTIMORE: (No. 2729 N.Charles Street, St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jennings Carroll Sanford

(a) RESIDENCE NO. 2729 N.Charles Street St. Ward Resident
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 7 mos. 13 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? 47 yrs. 7 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John L.Sanford

6 DATE OF BIRTH (month, day, and year) March-18-1880

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	47	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER St.John Carroll

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Placide

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mr.John L.Sanford (husband)

(Address) 2729 N.Charles Street

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/1 1927

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1927, to Nov 1, 1927,

that I last saw h[illegible] alive on Nov 1, 1927

and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia Convulsions

(duration) yrs. mos. 6 ds.

18 Where was disease contracted at home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

11/3, 1927 (Address) 1403 Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — Date of Burial Nov-4-27 19

20 UNDERTAKER STEVENS & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W.NORTH AVE.

R1/1

Be sure to write in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

CERTIFICATE OF DEATH.

E 27075

REGISTERED NO. E 37075

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hodges

(a) RESIDENCE NO. Mercy Hosp ST. WARD Emilie Heights

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3½ hrs How long in U. S., if of foreign birth? 0 yrs. 0 mos. 3½ hrs

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov - 2 - 1927

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs or 30 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Rezin Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co. Maryland

12 MAIDEN NAME OF MOTHER Grace Stansbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Mrs. Rezin Hodges (mother)

(Address) Emilie Heights Md

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 2 19 27

17 I HEREBY CERTIFY, That I attended deceased from 11-2-27, 19 , to 11-2-27 19

that I last saw him alive on 11-2-27, 19

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Atelectasis, Asphyxia

3 hrs - 30 min (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Post-mortem findings

(Signed) Geo. Pinkston M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Nov 3 19 27.

20 UNDERTAKER Stewart & Co

ADDRESS Balto Md.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

27076

CERTIFICATE OF DEATH

74E 27076

1-PLACE OF DEATH

REGISTERED NO. .....

City of BALTIMORE: (No. 334 S. Poppleton St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Miles

(a) RESIDENCE NO. 334 S. Poppleton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of: Carrie E. Miles

6 DATE OF BIRTH (month, day, and year): Nov 5 1856

7 AGE — Years: 70 — Months: — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad

(c) Name of employer: B & O R.R. Balto

9 BIRTHPLACE (city or town) ..... (State or country)

PARENTS

10 NAME OF FATHER: George Miles

11 BIRTHPLACE OF FATHER (City or town) ..... (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Lethia Foster

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country): Md

14 Informant: Carrie E. Miles

(Address): 334 S. Poppleton St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

NOV 3 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 1927, to Nov 2 1927, that I last saw h.. alive on Nov 1 1927, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) ... yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical Signs

(Signed) Jas F. Hooper M. D.

11/3 1927 (Address) 916 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: Nov 3 1927

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Fayette

IMPORTANT.—Statements must be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Blks.

Dr Wheeler 2127-W North Ave

E 27077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9-1-27 E 27077

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Herbert ST. 15-21 WARD)

2-FULL NAME William F. Bowers

(a) RESIDENCE NO. 1908 Herbert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clara P. Bowers

6 DATE OF BIRTH (month, day, and year) Aug 10 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 0 3

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town) Salt Mk
(State or country)

PARENTS

10 NAME OF FATHER Thomas Bowers

11 BIRTHPLACE OF FATHER (city or town) Balto Mk
(State or country)

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) Balto Mk
(State or country)

14 Informant Eliza Bowers
(Address) 1908 Herbert St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1927, to Nov 2, 1927, that I last saw him alive on Nov 1, 1927, and that death occurred, on the date stated above, at 12:55 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Linda Flanders, M. D.

11/2-1927 (Address) 2124 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 11-4 19 27

20 UNDERTAKER

ADDRESS 928 Park Ave

Read carefully, important! See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27078

CERTIFICATE OF DEATH

57 E 27078

1-PLACE OF DEATH University Hospital 19 REGISTERED NO.

City of BALTIMORE: (No. ~~2307 W Baltimore~~ GLENDORA HARGETT St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Glendora Hargett

(a) RESIDENCE NO. 2307 W Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Hargett

6 DATE OF BIRTH (month, day, and year) Dec 31 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	47	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Franklin Long.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Schleicher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant

(Address) ~~University Hospital~~

15 Filed NOV 2 - 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

November, 1

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1927, to Nov 1, 1927, that I last saw h[illegible] alive on Nov 1, 1927, and that death occurred, on the data stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY Bronchio-Pneumonia

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) [illegible] University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Olivet Frederick Md.	11-4 1927
20 UNDERTAKER	ADDRESS
J Bernard C Hartke	1046 S Paca St

Be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27079

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

100-001

E 27079

REGISTERED NO.

City of BALTIMORE: (No. 1106 Woodyear St. 16-23 Ward)

2-FULL NAME Avon Brown

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 1106 Woodyear St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 21, 1927.

7 AGE — Years: 1 — Months: — Days: 9 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md. 9/22, 1927

PARENTS

10 NAME OF FATHER Avon Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mamie Drane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant (Address) Avon Brown 1106 Woodyear St.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. ds.

(Signed) D. J. Hennessy M. D.

(Coroner)

Address 2572 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Zion — Date of Burial: Nov 3 1927

20 UNDERTAKER: Joseph A Lively — ADDRESS 409 N Mount

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—1-10-21 M&T 1500 Bks.

E 27080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10T-001

E 27080

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 N. Gilmor, St. ST. 19-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Marie Amie Butler

(a) RESIDENCE NO. 401 N. Gilmor St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25th. 1925

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
2	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jos. Mc. Butler Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Macon Ga.

12 MAIDEN NAME OF MOTHER Gladys Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Jos. Butler

(Address) 401 N. Gilmor St.

15 Filed NOV 3 - 1927, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-1927 19

17

I HEREBY CERTIFY, That I attended deceased from Oct 1st. 19 27 to Nov. 3rd 19 27.

that I last saw h alive on Nov 1st. 1927 19

and that death occurred, on the date stated above, at 5;40 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs mos 4 ds.

CONTRIBUTORY (Secondary) Uncomplicated

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of dea

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: Nov 5 1927

20 UNDERTAKER: Joseph A Lilly — ADDRESS: 409 W Mount

IRON is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27081

CERTIFICATE OF DEATH.

REGISTERED 37081

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE (No. Eastern Ave Md Hosp. St., 24 Ward)

2-FULL NAME John P. Bauer.

(a) RESIDENCE NO. 531 S Washington St. 2 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 10 mos. 15 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Kate Mary ann Bauer

6 DATE OF BIRTH (month, day, and year) Dec. 16th 1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry business, or establishment in which employed (or employ

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER John S. Bauer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Madeleda Franz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Gordon Tyler (Augusta)

(Address) 521 S Washington St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 31 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) ..... yrs. Instant mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. Instant mos. ..... ds.

(Signed) C C Yates M. D.

(Address) 143 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery Date of Burial Nov 4th 19 27

20 UNDERTAKER Lilly & Green ADDRESS 403 S Wolfe St

very important. See instructions on back of certificate. Each statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

E 27082

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 27082

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2905 Eastern Ave ST. 1-2 WARD)

2-FULL NAME Alexander J. Loss.

(a) RESIDENCE NO. 2905 Eastern Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine J. Loss.

6 DATE OF BIRTH (month, day, and year): May 11, 1858

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
69	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Messenger

(b) General nature of industry, business, or establishment in which employed (or employer): Custom House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10 NAME OF FATHER: Christian Loss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norway

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norway

14 Informant: Catherine Loss

(Address): 2905 Eastern Ave

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Nov 2, 1927

that I last saw him alive on Nov 2, 1927

and that death occurred, on the date stated above, at 2-30 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Sclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. R. L. Campbell, M. D.

Nov 2, 1927 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Nov 5-1927

20 UNDERTAKER: F. A. Kranz & Son. — ADDRESS: 703 Hanover

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27083

CERTIFICATE OF DEATH

65-001 E 27083

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3607 Old York road Ward 42-49)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Dewey Mennerick

(a) RESIDENCE NO. 3607 Old York road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie L Schmelz

6 DATE OF BIRTH (month, day, and year) October 29 - 1898

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	29	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 466

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER George A Mennerick

11 BIRTHPLACE OF FATHER (City or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Amelia Meelhorf

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs Marie Mennerick (Address) 3607 Old York road

15 Filed NOV 3 - 1927 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 - 1927

I HEREBY CERTIFY, That I attended deceased from January 5, 1925 to 11-2-1927 that I last saw h in alive on Nov 1 - 1927 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Splen. myelogenous leucaemia.

(duration) 2 yrs. 9 mos. 27 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) George Abner Saunders, M. D.

1927 (Address) 1517 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — Date of Burial Nov 4 1927

20 UNDERTAKER John Ulrich — ADDRESS 2138 Eutaw

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27084 ✓ E 27084

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4213 Old Frederick Road ST. (or) WARD)

2-FULL NAME William Hartman Bonnet

(a) RESIDENCE NO. 4213 Old Frederick Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 7 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie May Bonnet

6 DATE OF BIRTH (month, day, and year) Mar 2- 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sol. Katz

9 BIRTHPLACE (city or town) (State or country) Zanesville Ohio

PARENTS

10 NAME OF FATHER John W. Bonnet

11 BIRTHPLACE OF FATHER (city or town) Somerville (State or country) Ohio

12 MAIDEN NAME OF MOTHER Helena Ingemach

13 BIRTHPLACE OF MOTHER (city or town) Zanesville (State or country) Ohio

14 Informant Mrs W. H. Bonnet

(Address) 4212 Old Frederick Road

15 Filed NOV 2 1927 19 C. HAMMOND, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1927, to Nov. 1, 1927, that I last saw him alive on Nov. 1, 1927 and that death occurred, on the date stated above, at 1145 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris.

CONTRIBUTORY (Secondary) (duration) yrs. mos ds. Chr. Valvular disease - aortic & arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Fleming, M. D.

Nov 2 1927 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul's Catonsville — DATE OF BURIAL 11/4/1927

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson

Spec.–7-17-26—A Co.—200 Bks.

E 27085

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27085

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Clark

(a) RESIDENCE NO. 411 W. Biddle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Eleca Clark

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days
	62		

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. C

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) N. C

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) N. C

(State or country)

14 Informant Ella J. Carter

(Address) 411 W. Biddle

15 Filed NOV 3 - 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 19 27, to Nov. 1, 19 27

that I last saw h[illegible] alive on Nov. 1, 19 27

and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows: Epithelioma Carcinoma

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) duodenal hepatitis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) John D. Clark, M. D.

11-2 1927 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lenoir N. C — Date of Burial Nov 3 19 27

20 UNDERTAKER Geo W Coffey Son — ADDRESS Hickory N C

very important. See instructions on back of certificates. Exact statement of OCCUPATION is properly classified.

Spec.—1-12-23—M&T—500 Blks.

E 27086

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27086

CERTIFICATE OF DEATH.

84X

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Ochsenreiter

(a) RESIDENCE NO. 27 Forest Park, Rochelle Park N.J. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17-1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) New York

PARENTS

10 NAME OF FATHER HENRY OCHSENREITER

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) New York

12 MAIDEN NAME OF MOTHER Eva Lumpp

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) New York

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 .... RPK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 2 19 27

17 I HEREBY CERTIFY, That I attended deceased from September 14, 19 27, to November 2, 19 27, that I last saw him alive on November 2, 19 27 and that death occurred, on the date stated above, at 8:00 ? m.

The CAUSE OF DEATH* was as follows:

Brain Tumor
(Cerebellar glioma)

(duration) 4 yrs.? mos ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11-2-27

Was there an autopsy? Yes, limited to head.

What test confirmed diagnosis? Clinical & Operative

(Signed) George E. Pfeiffer, M. D.

11-3 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn New York — DATE OF BURIAL 11/8 19 27

20 UNDERTAKER Uhlemann Cook — ADDRESS 502 Park

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27087

CERTIFICATE OF DEATH.

E 27087

161-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp ST. 2-6-43 WARD)

2-FULL NAME Baby Boy Bauer

(a) RESIDENCE NO. 24 Fulton Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 2 '27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Sheldon Bauer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie Lerch

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sheldon Bauer
(Address) 24 Fulton Ave

15 Filed 1927 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 2, 19 27, to Nov. 3, 19 27

that I last saw h alive on Nov. 3, 19 27

and that death occurred, on the date stated above, at 7 20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. DiStefano M. D.

3, 1927 (Address) 1407 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL 11/4 1927

20 UNDERTAKER W M Cook

ADDRESS 502 E Balto

FAILURE to fill out all of the above items is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27088

CERTIFICATE OF DEATH.

31 E 27099

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4101 Lloyd ave ST. 28-63 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorthey Kellner

(a) RESIDENCE NO. 4101 Lloyd ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	28	9	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Typist
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Kaufman Kellner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Augusta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Augusta Kellner
(Address) 4101 Lloyd ave

15 Filed ..., 19... 1927 C. HARRISON JONES, M. D. Registrar
Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2nd 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 19th, 1918, to Nov. 2d, 1927.
that I last saw her alive on Nov 2d, 1927.
and that death occurred, on the date stated above, at 10 18 P m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 9 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Intestinal tuberculosis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.
Nov 3, 1927 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bells Hebrew Cem	11/4 1927
20 UNDERTAKER	ADDRESS 1437
Jack Lewis	7 E Fulton St

Spec.—12-9-25—A Co.—200 Bks.

E 27089

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27089

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH (No.) 2800 Northern Parkway Ward Hamilton

2-FULL NAME James K. Kennedy

(a) RESIDENCE NO. 2800 Northern Parkway Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sherwood Shooter

6 DATE OF BIRTH (month, day, and year): June 8th 1900

7 AGE: Years 27 Months 9 Days 25 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Elec. medical Co.

9 BIRTHPLACE (city or town): Ga.

(State or country)

PARENTS

10 NAME OF FATHER: John C. Kennedy

11 BIRTHPLACE OF FATHER (city or town): Kansas.

(State or country)

12 MAIDEN NAME OF MOTHER: Elvie.

13 BIRTHPLACE OF MOTHER (city or town): Ga.

(State or country)

14 Informant: Mrs. Sherwood Kennedy

(Address) 1620 W 4th St. Williamsport Pa.

15 Filed ....., 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27 Nov 3

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 19 27, to Nov 3, 19 27, that I last saw him alive on Nov 3, 19 27, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) .....yrs. .....mos. 3 ds.

18 Where was disease contracted if not at place of death? Not to my knowledge

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry L. Eves, M. D.

Nov 3 19 27 (Address) 531 Northfield Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wildwood Cem. Williamsport Md. Date of Burial Nov. 4 19 27

20 UNDERTAKER: John J. Bowman & Son. ADDRESS: 901 Holliday St.

very important. See instructions on back of certificates. CAUSE of DEATH and OCCUPATION is

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

27090

CERTIFICATE OF DEATH.

90 E 27090

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St., 12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Homer Byron Mathews

(a) RESIDENCE NO. 3306 Clifton Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willa Macon Mathews

6 DATE OF BIRTH (month, day, and year) September 19, 1892

7 AGE Years	Months	Days	IF LESS than 1 day....hrs. or....min.
35	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pres. New Jersey Roof Delaware

(b) General nature of industry, business, or establishment in which employed (or employer) Distributor of

(c) Name of employer Syrup for beverages

9 BIRTHPLACE (city or town)

(State or country) Georgia

PARENTS

10 NAME OF FATHER Homer B. Mathews

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Virginia Owen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Georgia

14 Informant T. E. Mathews

(Address) Lillman Apartment

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Dilatation of Heart

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) John Morrissey M. D.

(Coroner)

11/3. 1927 (Address) 3624 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cuthbert Ga — Date of Burial Nov 4 1927

20 UNDERTAKER E. L. Ray Stiffler — ADDRESS 1254 North Ave

very important. See instructions on back of certificate. Last Statement of OCCUPATIONS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27091 E 27091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1617 W Franklin St. WARD) 45

REGISTERED NO. 16427

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Effie Levi

(a) RESIDENCE NO. 1617 W Franklin St. WARD 94

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Levi

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years 45; Months; Days; If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Chas Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elsie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Elsie Levi

(Address): 1617 W Franklin St

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1927, to Nov 3, 1927.

that I last saw he alive on Nov 2, 1927

and that death occurred, on the date stated above, at 4:45 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) General carcinosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H Marco Milliam M. D.

11-3 1927 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 5 1927

20 UNDERTAKER: Daniel Easton — ADDRESS 916 [illegible] St.

Nov 4 1927 H Marco Milliam M. D. Registrar

Spec.-7-17-26—A Co.—200 Bks.

E 27092

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 27092

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1229 N Carey St. 8-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Welch

(a) RESIDENCE NO. 1229 N Carey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 1 - 1893

7 AGE: Years 34 Months 5 Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dancer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER: Thomas Welch

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: Laura Earhart

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: H H Mitchell

(Address) 1229 N Carey St

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 - 27, to Nov 1 - 27, that I last saw h[illegible] alive on Oct 26 - 27 and that death occurred, on the date stated above, at 9p - m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? - -

Did an operation precede death? - Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W J G Yates M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial 11/4-27

20 UNDERTAKER: M E Gorsom — ADDRESS 841 W 37th

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

DR-REICH-

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27093

CERTIFICATE OF DEATH.

31-E 27093

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3785 Gulow ST. 2002 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lenad D. Hasenzahl

(a) RESIDENCE NO. 3785 Gulow ST. 2nd WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Hasenzahl

6 DATE OF BIRTH (month, day, and year): June 13-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	30	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Herman B. Dupleix

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ft Wayne Indiana

12 MAIDEN NAME OF MOTHER: [illegible] Hassell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant (Address): Ernest Hasenzahl 3785 Gulow St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5th, 1927, to Oct. 24th, 1927, that I last saw her alive on Oct. 24th, 1927, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacilli of T.B. in Sputum

(Signed) E. N. Heck, M. D.

19 (Address) 1102 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Nov 4th 1927

20 UNDERTAKER: T. D. Hyslett — ADDRESS: 1850 W. Pratt St.

NOV 1927 C. HAMPSON JONES M.D.

Spec.–7-17-26–A Co.–200 Bks.

E 27094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

REGISTERED NO. E 27094

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St., 7-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Hartman.

(a) RESIDENCE NO. 922 N. Streeper St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. E. Hartman

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 41 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John Dilmer

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Marie ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Bohemia

14 Informant:

(Address): Heavrds.

15 Filed , 19 NOV 4 - 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/1/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1927 to Nov. 1, 1927 that I last saw h-e alive on Nov. 1, 1927 and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic

acute

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gen. and Surg.

(Signed) C. Hulse Burge, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — Date of Burial: Nov 5 1927

20 UNDERTAKER: John Fulda — ADDRESS: 1200 W Lemtard

very important. See instructions on back of certificates.

If statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Blks.

E 27095 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27095

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Falls Road—ST. 13-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mollie Maria Clark

(a) RESIDENCE No. 1027 Falls Road—ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elmer Clever Clark

6 DATE OF BIRTH (month, day, and year): Jan 27 1873

7 AGE: Years 54 Months 8 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer — None —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George W. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant (Address): Elsie Clark Daughter 1027 Falls Road

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 29th, 1927, to Oct 31st, 1927, that I last saw her alive on Oct 31st, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis not known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Savage Md — DATE OF BURIAL: Nov 4 1927

20 UNDERTAKER: Horace G. Prange — ADDRESS: 63 Hall Pl

HOW IS VERY IMPORTANT. See instructions on back of certificates.

NOV 4 1927 THOMPSON JONES, M.D.

Spec.—1-12-23—M&T—500 Blks.

E 27096 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27096

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 825 Towers St. St., 13 WARD) 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Abbott

(a) RESIDENCE NO. 807 Towers St. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank A. Abbott

6 DATE OF BIRTH (month, day, and year) Dec. 11-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Christopher Rupp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Yost

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Ellison

(Address) 825 Towers St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 19th, 1926, to Nov 3rd, 1927, that I last saw her alive on Nov 3rd, 1927 and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 807 Towers St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) From Drew M. D.

Nov 4, 19 27 (Address) 84 Law Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Nov. 5 1927

20 UNDERTAKER Horace H. Burgee ADDRESS 903 Hollins St.

Spec.-7-17-26-A Co.-200 Bks.

E 27097

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27097

CERTIFICATE OF DEATH

74-007

15-68

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1702 Bentalou St. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Olderman Solomon

(a) RESIDENCE NO. 1702 Bentalou St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Solomon

6 DATE OF BIRTH (month, day, and year) Jany. 30th. 1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland.

PARENTS

10 NAME OF FATHER Max Olderman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Ray Lyons

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mrs. Lebo

(Address) Birmingham, Alabama.

15 Filed , 19 JOHN H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Nov 2, 1927, that I last saw h alive on Nov 1, 1927 and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Hemiplegia

(duration) yrs. 1 mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C Lehman Smith, M. D.

, 19 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Hebrew Friendship Cem. Date of Burial 11/4/ 1927

20 UNDERTAKER Ward Sondheim ADDRESS 115-20 W. Pratt. Royal Ave.

very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 27098

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27098

101-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 310 N. Mount St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis Gross

(a) RESIDENCE NO. 310 N. Mount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Catherine Gross

6 DATE OF BIRTH (month, day, and year) November 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hod Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Sam'l Gross

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Catherine Gross (Address) 310. N. Mount St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D. NOV 4 - 1927 Port

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3. 1927 19

17 I HEREBY CERTIFY, That I attended deceased from 10-31-27, 19 ..... to 11-3-27, 19 .....,

that I last saw him alive on 11-2-27, 19 .....,

and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

..... (duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? 310 N Mount

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W W Boykin, M. D.

11-3, 1927 (Address) 618 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn	Nov 6 1927
20 UNDERTAKER	**ADDRESS**
Sam'l M. Chase Son	1400 Mahon

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 27099 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27099

CERTIFICATE OF DEATH.

74-001

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 879 N. Howard St. 11-24 Ward)

2-FULL NAME Rupert H. Wright

(a) RESIDENCE NO. 879 N. Howard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cathryn L. Wright

6 DATE OF BIRTH (month, day, and year): March 5, 1873

7 AGE — Years: 54 — Months: 7 — Days: 24

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Soft Drink Dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Own

9 BIRTHPLACE (city or town): Md.

(State or country): U.S.A.

PARENTS

10 NAME OF FATHER: Samuel Wright

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Penna.

12 MAIDEN NAME OF MOTHER: Lydia Lodge

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Penna.

14 Informant: Catherine Wright

(Address) 879 N. Howard St.

15 Filed....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Nov. 3, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBITORY (Secondary) Mental Illness

(duration) yrs. mos. ds.

(Signed) D. T. Hennessy M.D.

(Coroner)

19 27 (Address) 2572 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Nov 4 1927

20 UNDERTAKER: H. A. Jameson Jones Co. — ADDRESS: Funeral Director 1600 W. North Ave.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 27100

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27100

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 Fawson St ST. 24-35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James. M. Campbell.

(a) RESIDENCE NO. 1300 Fawson St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) R. R. work

(c) Name of employer B & O. R. R.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John M. Campbell

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Rose Kane

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Charlotte Campbell (Sister in law)
(Address) 1300 Fawson St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

NOV 5 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3, 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 27, 1927, to Oct 3, 1927,

that I last saw h[illegible] alive on Oct 2, 1927,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatitis Nephritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Chas. L. Stevens M. D.

11/3, 1927 (Address) 2878 Walbrook Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Cemetery

DATE OF BURIAL Nov 5 1927

20 UNDERTAKER Chas. L. Stevens

ADDRESS Forest Park

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27101

CERTIFICATE OF DEATH.

57 E 27101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. WARD)

2-FULL NAME Patrick Murphy

(a) RESIDENCE NO. 2816 Mayfield ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Catherine Murphy.

6 DATE OF BIRTH (month, day, and year): Jan 20 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police man

(b) General nature of industry, business, or establishment in which employed (or employer): City 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Murphy.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): J. P. Murphy. 2816 Mayfield ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 2 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1927, to Nov. 2, 1927, that I last saw h~~im~~ alive on Nov. 2, 1927 and that death occurred, on the date stated above, at 10 45 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Septicaemia (Staphylococcus aureus)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination Repeated blood cultures

(Signed) H. Hyland Jones, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hickey Cemetery - Blair — DATE OF BURIAL: Nov 5 1927

20 UNDERTAKER: George F. Ruth — ADDRESS: 1735 Harford ave.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27102

CERTIFICATE OF DEATH

90 E 27102

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 514 Somerset St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Henson

(a) RESIDENCE NO. 514 Somerset St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 Color or Race C

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Brown

6 DATE OF BIRTH (month, day, and year) Feb 8, 1881

7 AGE Years 46 Months 8 Days 25

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lubricer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER Annie Henson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Florence Henson

(Address) 514 Somerset St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 19 27, to Nov 3 19 27,

that I last saw he alive on Nov 3, 19 27,

and that death occurred, on the date stated above, at 3 A.M. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardio-Renal Disease

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

, 19 (Address) 608 Somerset St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — Date of Burial Nov 6 1927

20 UNDERTAKER John W Henderson — ADDRESS 1622 E Monument

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27103

CERTIFICATE OF DEATH.

16 ✓ E 27103

1-PLACE OF DEATH Lanta Belto Gen. Hospital

CITY OF BALTIMORE: (No. ~~29 W. West~~. ST. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther-Kay, Weyrich.

(a) RESIDENCE No. 29 W. West. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 31, 1927.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
			3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Albert Weyrich.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ida Muhly.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Albert Weyrich.
(Address) 29 W. West St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1927, to Nov 3, 1927

that I last saw her alive on Nov 3, 1927

and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH was as follows:

Malena —

(duration) yrs. mos 5 hrs

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. L. Yeyrich M. D.

(Address) 1 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emanuel Nov 4 1927

DATE OF BURIAL

20 UNDERTAKER: A. Howard Evans

ADDRESS: 88 E Fabay

Spec.—12-9-25—A Co.—200 Pks.

E 27104

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

E 27104

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Russell & Interwines St. Ward)

2-FULL NAME Minnie Price

(a) RESIDENCE NO. Interwines St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Price

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer 0

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Irene Price

(Address) 138 Russell St.

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

11/1/1927

17

I HEREBY CERTIFY, That I attended deceased from 10/24/ 1927, to 11/1/ 1927, that I last saw h.. alive on 10/30/ 1927, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

Is Where was disease contracted

If not at place of death

Did an operation precede death? ....Date of....

Was there an autopsy?

What test confirmed diagnosis

(Signed) Jno Hawes, M. D.

11/1/ 1927 (Address) 912 Eilmt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial 11/004 1927

20 UNDERTAKER Virginia A. Brooks ADDRESS 1463 N. Carey

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27105

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-22 3/V

E 27105

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals (C.H.) ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dewey Poindexter (Poindexer)

(a) RESIDENCE NO. 1207 Whatcoat st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Marshal Poindexer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Bertha Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1927

17

I HEREBY CERTIFY, That I attended deceased from June 24, 1927, to Nov. 2, 1927, that I last saw h im alive on Nov. 2, 1927 and that death occurred, on the date stated above, at 1.55 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos ds

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) F. E. Madden M. D.

(Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Nov. 5 1927

UNDERTAKER: Virginia P Brooks — ADDRESS: 1463 N. Carey

NOV 4 1927 H. A. HAWKINS, M. D.

Cor.—12-9-25—A Co.—200 Bks.

Schöneweiss

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27106

CERTIFICATE OF DEATH.

90

E 27106

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Schoenweiss

(a) RESIDENCE NO. 804 N Carey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fmal

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Jacob Schoenweiss

6 DATE OF BIRTH (month, day, and year) Sept 14 1840

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	86	1 mo	1 7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) " "

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) not known

14 Informant City Hospital

(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year) Nov 3 1927

17 I HEREBY CERTIFY, That I took charge of the remains, described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

Broken Compensation (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. mos. 1 ds.

(Signed) W. C. Hades M. D.

(Coroner)

1927 (Address) 143 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Nov 7 1927

20 UNDERTAKER William H Shriver ADDRESS 1018 Edmondson ave

Very Important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27107
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

129 E 27107
REGISTERED NO.

City of BALTIMORE: (No. 30 - E - 20 4th St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara M. Grant.

(a) RESIDENCE NO. 30 - E - 20 4th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS,

3 SEX: Female
4 Color or Race: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert Grant

6 DATE OF BIRTH (month, day, and year) Feb 28 1888

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	39	6	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John A Spriggs Sr
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Sara Brooke
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant John A Spriggs
(Address) 30 E 20th St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 19 27

17
I HEREBY CERTIFY, That I attended deceased from June 15, 19 27, to Nov 2, 19 27,
that I last saw h.. alive on Nov 2, 19 27,
and that death occurred, on the date stated above, at 1.45 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted X At Home
If not at place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) ..... M. D.

19 (Address) 2329 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial Nov 4 1927

20 UNDERTAKER Samuel F. Stanley & Bro ADDRESS 516 N Eutaw St

Very important. See instructions on back of certificate.

Spec.–7-17-26–A Co.—200 Bks.

E 27108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

14-001

E 27108

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1207 W Lexington St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah B Jackson

(a) RESIDENCE NO. 1207 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Arthur S. Jackson

6 DATE OF BIRTH (month, day, and year): January 12, 1853

7 AGE: Years 74 Months 9 Days 27

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER: Lewis Jones

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary A. Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant: Miss F Jackson

(Address) 1207 W Lexington St

15 Filed ..... 19 ..... Registrar

Per RMM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1927, to Nov 4 1927,

that I last saw her alive on Nov 3. 1927,

and that death occurred, on the date stated above, at 120 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Senile Deterioration

(duration) about 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry Cook M. D.

19 (Address) 1203 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park

Date of Burial NOV 7 19

20 UNDERTAKER Geo W Little

ADDRESS

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27109
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

66 E 27109
REGISTERED NO.

City of BALTIMORE: (No. 1309 Greenmount Ave St. 9-18 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles B. Malthan

(a) RESIDENCE NO. 1309 Greenmount Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine A. Malthan

6 DATE OF BIRTH (month, day, and year) May 13/1892

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	35	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John McGregor

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Malthan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Lanpkin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Wife

(Address) 1309 Greenmount Ave

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

(Signed) J. H. Weber M. D.
(Coroner)

11/4/27 (Address) 509 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial Nov 5 1927

20 UNDERTAKER George J. Ruth ADDRESS 1735 Madison Ave

Very Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27110

CERTIFICATE OF DEATH.

101-002

E 27110

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 729 E. Hoffman St St., 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James McBride

(a) RESIDENCE NO. 729 E. Hoffman St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl McBride

6 DATE OF BIRTH (month, day, and year) July 3/1885

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	42	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John McGregor

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thos. E. McBride

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Klifford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Wife

(Address) 729 E Hoffman St

15 Filed ....., 19 .....

Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

11/4, 19 27 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral Cemetery 11/7 1927

20 UNDERTAKER ADDRESS

George J. Ruth 1735 Harford Ave

Very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27111

CERTIFICATE OF DEATH.

129 E 27111

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1873 N. Gay ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis H. Twele

(a) RESIDENCE No. 1873 N Gay Street ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Twele

6 DATE OF BIRTH (month, day, and year) 3/9/1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr August C Twele

(Address) 1873 N Gay Street

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3 1927

17

I HEREBY CERTIFY, That I attended deceased from July 5 , 1927 , to November 3 , 1927 ,

that I last saw him alive on November 1 , 1927 ,

and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterial Hypertension

Aortic Insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Autumn

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and Examination

(Signed) Albert Dorsey Hilts M. D.

11/3 , 1927 (Address) 2025 E. High St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 11/5 1927

20 UNDERTAKER Albert L Hiltz Jr

ADDRESS 1606 N Chester

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

27112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 27112

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 3018 Berkshire Road St. Arcadia Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Hymby

(a) Residence No. 3018 Berkshire Road St. Arcadia Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced. (Write the word): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Edwin J. Hymby

6-DATE OF BIRTH (month, day and year): March 21st 1859

7-AGE: 68 yrs. 7 mos. 12 ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): South Hampton England

PARENTS.
10-NAME OF FATHER: George Grace
11-BIRTHPLACE OF FATHER (city or town) (State or Country): S. Hampton England
12-MAIDEN NAME OF MOTHER: Charlotte Hymby
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): S. Hampton England

14- (Informant): Edwin J. Hymby
(Address): 3018 Berkshire Road

15- Filed ... 192 ... A. M. ... Registrar.

W A - 1927 C. HAMPSON JONES

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Nov 2nd 1927

17- I HEREBY CERTIFY, That I attended deceased from June 10 1927 to Nov 2 1927
that I last saw h. alive on Nov 1st 1927
and that death occurred, on the date stated above, at 12 Noon m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(Duration) yrs. 6 mos. ds

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Sign & Symptoms

(Signed) Edwin J. Benson M D
Nov 3 1927 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Nov. 5th 1927

20-UNDERTAKER: Frederick Lassahn — ADDRESS: Govans Fullerton

Spec.—1-12-23—M&T—500 Bks.

E 27113

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8th Street FairField St. 25-7h WARD) 98

2-FULL NAME William Boyd.

(a) RESIDENCE NO. 8th Street Fair Field Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Hart Inman

6 DATE OF BIRTH (month, day, and year) Unknown 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal & Wood Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Susex Co. Va.

PARENTS

10 NAME OF FATHER Wm. Boyd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mollie Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Wm Boyd son & Nest Fairfield

15 Filed — —, 19— Registrar RKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/20 —, 1927, to 11/1 —, 1927, that I last saw him alive on 11/1 —, 1927, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Congestion of Lungs

(duration) — yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Arthur J. [illegible], M. D.

, 19 (Address) 1340 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnach Branch Cem.	Nov. 4, 1927

20 UNDERTAKER Mrs. P. A. Elliott ADDRESS 1227 Ashland Ave.

NOV 4 1927 HARRISON JONES, M.D.

Spec.—1-10-21—M&T—1500 Bks.

E 27114

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27114

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3129 Elliott ST., 1-1 WARD)

2-FULL NAME George H Ebsworth

(a) RESIDENCE NO.... 3124 Elliott ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 8 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of [redacted] Martha B Ebsworth

6 DATE OF BIRTH (month, day, and year) February 5th 1864

7 AGE	Years	Months	Days 26	If LESS than 1 day, hrs. or min.
	63	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Daniel Ebsworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. A.

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Martha B Ebsworth
(Address) 3124 Elliott St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1st 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1927, to Nov 1, 1927.

that I last saw h in alive on Nov 1, 1927,

and that death occurred, on the date stated above, at 5 20 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis + Arterial Hypertension

(duration) Aut. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P, S + A

(Signed) Harold C. Pillsbury, M. D.

, 19 (Address) 31 E. Mount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Nov 5th 1927
20 UNDERTAKER George Schilling + Sons	ADDRESS 1120 E Mt

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27115 — 45E 27115

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Le White Hospital Ave 7-24

CITY OF BALTIMORE: (No. 1029 Madison ST. 7 WARD)

2-FULL NAME Susan J Kelly

(a) RESIDENCE NO. 1311 Division St / ~~1029 Madison~~ ST. _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred 50+ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sam Kelly

6 DATE OF BIRTH (month, day, and year): Jan 12, 1860

7 AGE — Years: 67 — Months: 8 — Days: 5 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife - Ex

(b) General nature of industry, business, or establishment in which employed (or employer): Store-Keeper

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Washington Co Md

PARENTS

10 NAME OF FATHER: Alexander Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington Co. Md.

12 MAIDEN NAME OF MOTHER: Ann Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hamer B. Browne 1904 Madison ave.

15 Filed _____, 19__ Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1926, to Nov 2, 1927, that I last saw her alive on Nov 1, 1927 and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Rectal Cancer, mal.

(duration) 2? yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1311 Division St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

11/3, 1927 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 11/4/27

20 UNDERTAKER: Wm. Ge. H. Holland — ADDRESS: 1631 Druid Hill Ave

NOV 1 1927 HARRISON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27116

CERTIFICATE OF DEATH.

188-003 E 27116

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hosp. 15-18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Hooker

(a) RESIDENCE NO. 1504 Braddish Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 4, 1907

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	10	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Joseph G. Hooker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Kehoe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Estelle Hooker

(Address) 1504 Braddish Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Accidental Drowning

(duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

June 3, 1927 (Address) 25 W. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem. Date of Burial June 1927

20 UNDERTAKER Harry W. Ellen ADDRESS 1926 W. Baltimore

Copy Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27117

CERTIFICATE OF DEATH.

161-001 E 27117

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1932 Wilhelm St., 20-26 Ward)

2-FULL NAME Gertrude C. Schwartz

(a) RESIDENCE NO. 1932 Wilhelm Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Oct 26/27

7 AGE: Years — Months — Days 6 5

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Geo H. Schwartz

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Fieck

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Gertrude Schwartz

(Address) 1932 Wilhelm St

15 Filed ..... 19 .....

Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest or inquiry) thereon and from the evidence obtained by Inquest find that said deceased came to death (Autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

Lived 6 Days —

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Signed Wm B. Horton M.D.

Nov 2nd 1927 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

C. HARTSOCK

JOHNS HOPKINS HOSPITAL

1927 Dept. of Municipal Health.

Very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27118

CERTIFICATE OF DEATH.

117 E 27118

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 3-5 Ward)

2-FULL NAME Frances Budacz

(a) RESIDENCE NO. 1518 Eastern Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Budacz

6 DATE OF BIRTH (month, day, and year) March 2 1895

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Martin Skatnicki

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Frank Budacz

(Address) 1518 Eastern Ave

15 Filed 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927

11-2

17

I HEREBY CERTIFY, That I attended deceased from 11-1, 1927, to 11-2, 1927, that I last saw h[illegible] alive on 11-2, 1927, and that death occurred, on the date stated above, at 12.40 P m.

The CAUSE OF DEATH* was as-follows:

Chronic appendicitis

Laceration of Cervix

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden death after operation probably due to cerebral embolism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 11-2-27

Was there an autopsy? not — appendix

What test confirmed diagnosis? clinical

(Signed) O. J. Knapp, M. D.

11-2, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Rosary cem	Nov 5 1927
20 UNDERTAKER	**ADDRESS**
John M Weber	1803 Bank

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27119

CERTIFICATE OF DEATH

X 100E 001 27119

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St. Joseph's Hospital 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Grant Smith SPARROW POINT

(a) RESIDENCE NO. 1315 Rockwood Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30. 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Elmer Smith

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Lindeman

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Elmer Smith

(Address) Sparrows Point Md.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

11/3/27

17 I HEREBY CERTIFY, That I attended deceased from 11/1/27, 19, to 11/3/27, 19,

that I last saw h alive on 11/3/27, 19,

and that death occurred, on the date stated above, at 10:55 A m.

The CAUSE OF DEATH* was as follows:

broncho-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H Lawrence Fuhrney, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — Date of Burial Nov. 5 1927

20 UNDERTAKER L. Sander & Sons — ADDRESS 1710 Pleasant

Very important. See instructions on back of certificates.

NOV 1927 C. HARRISON JONES, M.D.

Spec--12-23-21--E.B.R.S.--400 Bks.

E 27120

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 520 East 38th St. St., Ward)

Registered No. 9-47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret C. Hartman

(a) Residence No. 520 East 38th St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, Married, Widowed, ~~or Divorced~~ (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Hartman

6-DATE OF BIRTH (month, day and year) Sept 21 1860

7-AGE. 67 yrs. 2 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John G. Beil

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Margaret Loch.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany.

11- (Informant) Mrs. Margaret M. Dietrich. (Address) 520 East 38th St.

15- Filed, 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 3 1927

17- I HEREBY CERTIFY, That I attended deceased from Oct 31st 1927 to Nov. 3rd 1927

that I last saw her alive on Nov 2nd 1927

and that death occurred, on the date stated above, at 5 45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo W. Morgan M.D.

11/3/ 1927 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/5/27 19
20-UNDERTAKER. Mary M. Wiesefeld	ADDRESS 501 E. 22nd

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

27121 CERTIFICATE OF DEATH 27121

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 29E

CITY OF BALTIMORE: (No. 3-59 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Lutbeter

(a) RESIDENCE NO. 1325 W. North Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of ~~Mrs. Robert E.~~ Lavinia Colton Lutbeter

6 DATE OF BIRTH (month, day, and year) Nov. 8. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	63	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Chas Lutbeter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Sarah Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Lavinia Colton Lutbeter (Address) 1325 W North Ave.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1927, to Nov 4, 1927, that I last saw h[illegible] alive on Nov 4, 1927 and that death occurred, on the date stated above, at 12 50 a m

The CAUSE OF DEATH* was as follows:

Chronic nephritis, uremia

(duration) yrs. mos ds

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bl. chemistry.

(Signed) Palmer F. C. Williams M. D.

Nov 4 1927 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Nov 7 1927
20 UNDERTAKER Wm Fleckner Sons	ADDRESS North Ave

Spec.-7-17-26—A Co.—200 Bks.

E 27122

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27122

CERTIFICATE OF DEATH

1-PLACE OF DEATH University of Maryland Hospital REGISTERED NO. 135

City of BALTIMORE: (No. M. W. St. 13-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hunter

(a) RESIDENCE NO. 1817 N. Fulton Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Betty Hunter

6 DATE OF BIRTH (month, day, and year): Aug 2-1861

7 AGE — Years: 66 Months: 3 Days: 0 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): (State or country) Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): (State or country) U

12 MAIDEN NAME OF MOTHER: Mary E. Norris

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Unknown

14 Informant: Mrs. B. R. Thompson (Address) 3107 E. Fayette St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 2, 19 27

17 I HEREBY CERTIFY, That I attended deceased from 10/18/. 1927, to 11/2/ 1927, that I last saw h[illegible] alive on Nov. 2 1927, and that death occurred, on the date stated above, at 3:45 PM.

The CAUSE OF DEATH* was as follows: Adenoma of Prostate

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/31/27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) C. W. Peake M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. Date of Burial: Nov 5 1927

20 UNDERTAKER: Wm Fickuch & Sons ADDRESS: North Ave

Very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27123

CERTIFICATE OF DEATH

46 E 27123

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3604 Calloway Ave St. 15-62 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May W. Leird

(a) RESIDENCE NO. 3604 Calloway Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Leird

6 DATE OF BIRTH (month, day, and year): Jan 28 1876

7 AGE: Years 51 Months 9 Days 6 — If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harrisonburg Va

PARENTS

10 NAME OF FATHER: Hamilton E. Wolf

11 BIRTHPLACE OF FATHER (City or town) (State or country): Charleston S. C.

12 MAIDEN NAME OF MOTHER: Hannah Frank

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balt-Md

14 Informant: Samuel Leird

(Address): 3604 Calloway Ave

15 Filed 19 Registrar

RFM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Nov. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16 1927 to Nov 3 1927

that I last saw h.. alive on Nov 1 1927

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovaries

(duration) yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary): Myocarditis (Myocardial failure)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 9 1927

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Laparotomy & Clinical course

(Signed) Louis P. Hamburger, M. D.

Nov 3. 1927 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cemetery — Date of Burial: Nov 6 1927

20 UNDERTAKER: J. Amaos & Co — ADDRESS: 2432 Reisterstown Rd.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27124

CERTIFICATE OF DEATH.

74 E 27124

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 615 Gorsuch Avenue ST., 9-44 WARD)

2-FULL NAME H. Lawson Bordley

(a) RESIDENCE NO. 615 Gorsuch Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Laura R. Brown

6 DATE OF BIRTH (month, day, and year) Mar. 27, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer) Construction

(c) Name of employer H. O. Firor

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry F. Bordley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Thompson

13 BIRTHPLACE OF MOTHER (city or town) ----
(State or country) ----

14 Informant Mrs. Laura R. Bordley
(Address) 615 Gorsuch Avenue

15 Filed 1927, 19 Registrar

1927 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Octr 4, 1927, to Nov 3, 1927, that I last saw h[im] alive on Nov 3, 1927, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis 1 year
Cerebral Hemorrhage 3 days

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. W. Bishop, M. D.

Nov 4, 1926 (Address) 501 Sheridan Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. John's P. E. Cemetery — DATE OF BURIAL: 11/6 19 27

20 UNDERTAKER: Henry U. Meyers & Son — ADDRESS: 405 N. Calvert

Spec.—1-12-23—M&T—500 Bks.

E 27125

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27125

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals (1-1) ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Way

(a) RESIDENCE NO. 818 S. East ave. ST. 26 WARD

(Usual place of abode)

Leagth of residence in city or town where death occurred life yrs mos ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth J. Way.

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER George F. Way

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Sarah Roslock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Hospital Records (Address)

15 Filed 11-3-27, 19 APH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 19 27

17

I HEREBY CERTIFY, That I attended deceased from July 1, 19 27, to Nov. 3, 19 27,

that I last saw him alive on Nov. 3, 19 27

and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Pul Tbc

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tbc Enteritis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Clinical

(Signed) F. E. Madden, M. D.

11-3-27, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Nov. 6th 1927

20 UNDERTAKER Lilly Bros

ADDRESS 403 S. Wolfe St.

Spec.—1-12-23—M&T—500 Blks.

E 27126 HEALTH DEPARTMENT—CITY OF BALTIMORE 20 V 27126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy (Hospital) (WARD) 7th

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Gould

(a) RESIDENCE No. 676 Bond St. WARD 4th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lottie M. Gould

6 DATE OF BIRTH (month, day, and year) March 17, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS

10 NAME OF FATHER George Gould

11 BIRTHPLACE OF FATHER (city or town) Nova Scotia (State or country)

12 MAIDEN NAME OF MOTHER Miriam M. Collett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Lottie M. Gould (Address) 676 South 12th St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-1927

17 I HEREBY CERTIFY, That I attended deceased from 10-19-1927 to 11-3-1927

that I last saw him alive on 11-3-1927, 19

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix

Left Metastasis to

Left Lung.

(duration) yrs. mos 2 ds

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Findings

(Signed) [illegible], M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Humicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Mass. DATE OF BURIAL Nov 5th 1927

20 UNDERTAKER Penna R.R. to Balt. ADDRESS

Lilly & Zeiler 103 S. [illegible]

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27127

CERTIFICATE OF DEATH.

74 E 01 27127

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5 N. Linwood Ave ST., (6-11 WARD)

2-FULL NAME John F. Jackman

(a) RESIDENCE NO. 5 N. Linwood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Clara Jackman

6 DATE OF BIRTH (month, day, and year) Dec 13-1875

7 AGE 51 Years 10 Months Days If LESS than 1 day, hrs. or min.
52 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Candy Factory

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Jackman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Mary Cloak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire.

14 Informant Clara Jackman
(Address) 5 N. Linwood Ave

15 Filed ..... 2 ....., 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1927, to Nov 2, 1927,

that I last saw ~~him~~ alive on Nov 2, 1927,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. C. Hampson Jones, M. D.

(Address) 6111 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cathedral Cem

DATE OF BURIAL 11/3 1927

20 UNDERTAKER J. F. Moran

ADDRESS 300 E. Baltimore

Spec.—1-12-27—M&T—500 Blks.

E 27128

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27128

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 S. Ellwood ave ST., 1-2 WARD)

2-FULL NAME Bertha Eyth

(a) RESIDENCE NO. 24 S. Ellwood ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of George Eyth

6 DATE OF BIRTH (month, day, and year) May 25 1849

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
78	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Gustav Heil

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Koffmann

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant C. Hayes Eyth
(Address) 24 S. Ellwood

15 Filed ..... , 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 14 1927 to Nov. 7 1927

that I last saw h alive on Nov. 7 1927

and that death occurred, on the date stated above, at 10:15 m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis,

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. W Wyman M. D.

(Address) 1710 E 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn burn DATE OF BURIAL 11/6 1927

20 UNDERTAKER J. A. Moran ADDRESS 3000 E Baltimore

Spec.—1-12-23—M&T—500 Blks.

E 27129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 27129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 723 Harvey (St.) 94-33 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Walker

(a) RESIDENCE NO. 723 Harvey ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 11 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	52	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) B&O R R

(c) Name of employer B&O R R

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard B Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Lena Young

(Address) 723 Harvey St

15 Filed ..... 19 ..... G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1927

17

I HEREBY CERTIFY, That I attended deceased from May 9, 1927, to Nov 4, 1927, that I last saw h[illegible] alive on Nov 3, 1927, and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

unknown

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy

(Signed) Emile Elliott, M. D.

Nov 9, 1927 (Address) 1319 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Nov. 8 1927

20 UNDERTAKER: George W. Zirkler — ADDRESS: 1737 E. Eager St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27130

CERTIFICATE OF DEATH.

X 89 E 27130

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Radiator Co. Union Ave. St. 13-57 (Ward)

2-FULL NAME Walter R. Henry

(a) RESIDENCE NO. 1209 Fairfield Rd St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Sophia M Henry

6 DATE OF BIRTH (month, day, and year) Dec 1 - 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Balto. Co

PARENTS

10 NAME OF FATHER Jacob K. P. Henry

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Balto Co

12 MAIDEN NAME OF MOTHER Mary R. Gill

13 BIRTHPLACE OF MOTHER (City or town) .....

(State or country) Balto Co Md

14 Informant M. E. M. Henry

(Address) 1209 Fairfield Rd

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/3 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cirrhosis Hepatis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Saml Mossuser M. D.

(Coroner)

11/3, 1927 (Address) 3692 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rosedale Balto Co Date of Burial Nov 6 1927

20 UNDERTAKER A. L. Marshall ADDRESS 3539 Falls Road

Very Important. See INSTRUCTIONS on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 27131

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27131

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1402 Union Ave (St.) 13-57 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Barton

(a) RESIDENCE NO. 1402 Union Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Martha Boote Barton

6 DATE OF BIRTH (month, day, and year) Apr 15-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 006

(b) General nature of industry, business, or establishment in which employed (or employer) Black Smith

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Stephen Barton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co.

12 MAIDEN NAME OF MOTHER Rebecca Barnhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Martha Boote Barton

(Address) 1402 Union Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct ., 1927, to Nov 2 , 1927,

that I last saw h[illegible] alive on Nov. 2 , 1927,

and that death occurred, on the date stated above, at 2-30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary odema

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) ... Smith , M. D.

(Address) 3429 Chesterfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL 11-5-27 19

20 UNDERTAKER A S Marshall ADDRESS 3539 Edmondson Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27132

CERTIFICATE OF DEATH.

31 E 27132

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. So. Balt. Gen. Hosp St. 27-48 Ward)

2-FULL NAME Mary R. Jefferson

(a) RESIDENCE NO. 5404 Cleveland Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	39	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Secretary

(b) General nature of industry, business, or establishment in which employed (or employer): Dr Etheridge

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Noah Jefferson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Hilda Carter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Noah Jefferson

(Address) 5404 Cleveland ave

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1927, to Nov. 2, 1927, that I last saw h.l.v. alive on Nov. 2, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) ____ yrs. ____ mos. 21 ds.

CONTRIBUTORY (Secondary) Fibroid Tuberculous Lung (duration) 8 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) William W. Chew, M. D.

, 19 (Address) South Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial Nov 5 19 27

20 UNDERTAKER: Franklin Waltz ADDRESS 709 W 33rd St.

Any duplicate, not bearing the signature of C. HAMPSON JONES, M. D., Registrar of Vital Statistics, will be void.

1927

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27133

CERTIFICATE OF DEATH.

99-00 E 27133

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2635 St. Paul ST. 12-50 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hall School

(a) RESIDENCE No. 2635 St. Paul ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew School

6 DATE OF BIRTH (month, day, and year) Dec 28 1827

7 AGE — Years: 99 — Months: 10 — Days: 6 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER James Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Catherine F. Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Miss Helen School
(Address) 2635 St. Paul St

15 Filed ..... 19 .....
1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1927, to Nov 3rd, 1927, that I last saw h[illegible] alive on Nov 3rd, 1927, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute pulmonary edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert T. Mitchell M. D.

Nov 4, 1927 (Address) 1117 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Nov 4 1927

20 UNDERTAKER: Chas. E. Franck

ADDRESS: 22 Madison Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27134

CERTIFICATE OF DEATH.

74 E 27134

1-PLACE OF DEATH

City of BALTIMORE: (No.) 5537 N. Hoffman St. (Ward) 17-24

2-FULL NAME Phillips Buckner

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 5537 N. Hoffman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colrd

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Blanche Buckner

6 DATE OF BIRTH (month, day, and year): About 1875

7 AGE: Years: about 52 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chef

(b) General nature of industry, business, or establishment in which employed (or employer): O't

(c) Name of employer

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER John Buckner

11 BIRTHPLACE OF FATHER (city or town): Va.

(State or country)

12 MAIDEN NAME OF MOTHER Lucy Williams

13 BIRTHPLACE OF MOTHER (city or town): Va.

(State or country)

14 Informant: Mrs. B. Buckner

(Address) 553 N. Hoffman St.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hundley M. D.

(Coroner)

Nov 2, 19 27 (Address) 2572 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery Date of Burial 11/5/ 1927

20 UNDERTAKER: John R. Toadvine ADDRESS 1027 Druid Hill Ave.

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 E 27135

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1608 Linden Ave ST. 14-20 WARD)

2-FULL NAME Mary Frances Hotchkiss

(a) RESIDENCE NO. 1608 Linden Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph D. Hotchkiss

6 DATE OF BIRTH (month, day, and year) Aug 21-1847

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
80	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Loper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Honora Loper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Jennie E. Hotchkiss
(Address) 1608 Linden Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Several years, 19..., to Nov 4, 1927, that I last saw her alive on Nov. 3, 1927, and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Senual Carcinoma

about 2 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Impacted Fecal Matter about 2 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. A. Steuart, M. D.

, 19 (Address) 7 E. Pleasant

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery — DATE OF BURIAL 11/5 1927

20 UNDERTAKER Kutsen & Poe — ADDRESS 1733 W. Lafayette Ave.

1927 C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMO

E 27136

CERTIFICATE OF DEATH.

16-22-31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., WARD)

2-FULL NAME Robert Brooks

(a) RESIDENCE NO. 1147 N. Mount st. ST., WARD (If non-resident give city

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos ds. How long in U. S., if of foreign birth? yrs.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma Brooks

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Hinshet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 [illegible]

17 I HEREBY CERTIFY, That I attended deceased from July 7 , 19 27 , to Nov. 3 , 19 27 ,

that I last saw h alive on Nov. 3 , 19 27

and that death occurred, on the date stated above, at 5.20 P. m

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Clinical and autopsy

(Signed) [illegible] M. D.

11-4-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL Nov 6 19 27

20 UNDERTAKER [illegible] ADDRESS [illegible]

Spec.—1-12-23—M&T—500 Blks.

E 27137

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27137

CERTIFICATE OF DEATH.

REGISTERED NO. 1274

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1607 N Wolfe ST. (WARD) 8-17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Hauage

(a) RESIDENCE NO. 1607 N Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emelia H Hauage

6 DATE OF BIRTH (month, day, and year): June 13 1848

7 AGE — Years: 79 Months: 4 Days: 20 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Emelia Hauage

(Address) 1607 N Wolfe St

15 Filed . . . 19 . . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Nov 3, 1927, that I last saw him alive on Nov 1 1927 and that death occurred, on the date stated above, at 5.28 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E Gill Hall, M. D.

Nov 4, 1927 (Address) E Gill Hall MD

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Nov 7 1927

20 UNDERTAKER: John Lee & Co

ADDRESS: 2008 Orleans

HAMPSON JONES, M. D.

Spec.—1-12 23—M&T—500 Bks.

Dr Wm M. Miller Johns Hopkins Hosp

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27138

CERTIFICATE OF DEATH.

135

E 27138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 911 Homestead ST. 10-14 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. K. Lewis

(a) RESIDENCE No. 911 Homestead ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary E. Lewis

6 DATE OF BIRTH (month, day, and year) Nov 14 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Watchmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. R. R. Co

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER John Lewis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mary E. Lewis

(Address) 911 Homestead St

15 Filed . . . . , 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1927, to Nov 4, 1927,

that I last saw him alive on Nov 4, 1927,

and that death occurred, on the date stated above, at 2:45 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

16 yrs 6 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Benign Prostatic hypertrophy (duration) 10? yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 24, 1927

No

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) William M Millar, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Nov 7 1927

20 UNDERTAKER Wm Cook

ADDRESS 502 Eutaw

Spec.—1-12 23—M&T—500 Bks.

E 27139

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27139

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 N. Monroe St. 16-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Sapp

(a) RESIDENCE NO. 800 N. Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of William Sapp

6 DATE OF BIRTH (month, day, and year) 12-29-1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Francis Zapp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E Sapp (Address) 800 N. Monroe St

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2. 1927

17

I HEREBY CERTIFY, That I attended deceased from during the past 14 yrs. 1927, that I last saw h- alive on date of death 19, and that death occurred, on the date stated above, at 5:10 A. m.

The CAUSE OF DEATH* was as follows:

Death was due to a long standing interstitial nephritis

(duration) Many yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Courtney Lee Hanks, M. D.

, 19 (Address) 824 N. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 11/5 1927.

20 UNDERTAKER Wm Cook

ADDRESS 502 E Monk

Cor.—12-9-25—A Co.—200 Bks.

E 27140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

87 ~E 27140

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 239 W. Henrietta St. St. 27-21 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Fauntleroy.(C)

(a) RESIDENCE NO. 239 W. Henrietta St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 8 mos. 29 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Widower

5a If married, widowed, or XXXXX HUSBAND of XXXXXXXX Carrie Fauntleroy.

6 DATE OF BIRTH (month, day, and year) July 4, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Rebecca Butler(sisterinlaw)

(Address) 2401 Druid Hill Avee.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 2, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH*, was as follows:

Chronic Pericarditis.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Wm. H. Feldmann M. D. (Coroner)

11/4 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Date of Burial Nov. 7 19 27

20 UNDERTAKER Clarence E. Wright ADDRESS 1364 N. Gay St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27141

CERTIFICATE OF DEATH.

11-24 74-001 E 27141

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 927 Madison ave St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George T. Gant

(a) RESIDENCE NO. 927 Madison ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Victoria Gant.

6 DATE OF BIRTH (month, day, and year): About 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer): Keeper

(c) Name of employer

9 BIRTHPLACE (city or town): Washington D.C.

(State or country)

PARENTS

10 NAME OF FATHER: Henry Gant

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Clinton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Clinton

14 Informant: Victoria Gant

(Address): 927 Madison Ave

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192?

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

(Address) 2512 Eutaw

19 ..... 192?

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn Cem Nov 19??

Date of Burial

20 UNDERTAKER: Samuel G. Hendley

ADDRESS 1778

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27142

CERTIFICATE OF DEATH

100 E 27142

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. LTIMORE CITY HOSPI St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Brown.

(a) RESIDENCE NO. 1102 Druid Hill Road. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 54 Months Days IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Frederick Brown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant ...L. CITY HOS...

(Address) Druid Hill

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/31 1927

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1927 to Nov. 3, 1927.

that I last saw him alive on Nov. 3, 1927.

and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ....yrs. ....mos. 5 da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General appearance.

(Signed) C. Hubert Brown, M. D.

. 19 (Address) BALTIMORE CITY HOS...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

Date of Burial: 11-7 1927

20 UNDERTAKER: George T. A. Gittings

ADDRESS: 1334 Druid Hill Ave

Very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27143

CERTIFICATE OF DEATH.

31 E 27143

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. So. Balt. Gen. Hosp. St. 1133 Linden Ave.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Vayne

(a) RESIDENCE NO. 1017 Riverside Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.

(State or country)

PARENTS

10 NAME OF FATHER Wm. H. Vayne

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER ~~Laura~~ Kane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Hospital Record

(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV. 3 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 23 1927, to Nov. 3, 1927,

that I last saw him alive on Nov. 3, 1927,

and that death occurred, on the date stated above, at 6 45P m.

The CAUSE OF DEATH* was as follows:

Terminal Hypostatic Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Card.-o-Vas-Renal Disease

Fibroid Tuberculosis (Pulmonary) Cirrhosis of Liver.

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross Exam

(Signed) E. Uhrmann, M. D.

. 19 (Address) So. Balto Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cruthsville Md. Date of Burial 11-6 1927

20 UNDERTAKER E. B. Hart ADDRESS 115 E Lexington

Very important. See instructions on back of certificate.

Corr.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27144

CERTIFICATE OF DEATH.

187-E 27144

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. Port Covington, W.Md.R.R.Co. St., 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Claude Mummaugh.

(a) RESIDENCE NO. 2208 Preston Place. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. _____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Divorced.

5a If XXXXXXXXXX or divorced HUSBAND of (XXXXXXX Amelia Mummaugh.

6 DATE OF BIRTH (month, day, and year) March 4, 1884.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist.

(b) General nature of industry, business, or establishment in which employed (or employer) W.Md R.R.Co.

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Westminster, Md.

PARENTS

10 NAME OF FATHER George Mummaugh.

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Ward.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Maryland.

14 Informant Lawrence Mummaugh, (brother)

(Address) 2208 Preston Place.

15 Filed_____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 3, 1927. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Struck on the head by a steel rod while at work on a lathe. Occidental Death.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Otto M. Rembrandt M. D.

(Coroner)

11/5 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Westminster Md Nov. 6 1927

20 UNDERTAKER Chas. H. Brockbank ADDRESS 1400 Balto St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27145

CERTIFICATE OF DEATH.

66 E 27145

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2608 N. Calvert St. 12 Ward)

2-FULL NAME Jos A. Breidenbach

(a) RESIDENCE NO. 2605 N. Calvert St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7 1878

7 AGE: Years 49 Months Days

If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (City or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Breidenbach

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germ.

12 MAIDEN NAME OF MOTHER: Mary Stricker

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Martin Breidenbach

(Address): Minneapolis

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John Monroe M. D.

(Coroner)

11/3, 1927 (Address) 632 Poland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen S. Dakota

Date of Burial 19

20 UNDERTAKER: Jos. J. Burns Son

ADDRESS: 156 N. Luzerne

Spec.-7-17-26—A Co.—200 Bks.

E 27146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27146

100-681

1-PLACE OF DEATH St Agnes Hospital REGISTERED NO. 27-54

City of BALTIMORE: (No. Emens Memorial St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. A. Mabin.

(a) RESIDENCE NO. Lenoak Rd. Mt Washington St. Ward Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Taylor

6 DATE OF BIRTH (month, day, and year) Oct 7-1840

7 AGE: Years 87 Months Days 25 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Mabin

11 BIRTHPLACE OF FATHER (City or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Eliz Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Geo. A. Mabin. (Address) Lenoke Rd. Mt Washington

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar RFH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Nov. 4 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1927, to Nov. 4, 1927, that I last saw h[e] alive on Nov. 4, 1927, and that death occurred, on the date stated above, at 4 15 a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Arthritis - Gen Art Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances L. Badgley, M. D.

19 (Address) St Agnes' Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Nov. 7 27

20 UNDERTAKER Martin Fahey Sons ADDRESS

Very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27147

CERTIFICATE OF DEATH.

66 E 27147

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1306 W. Baltimore St. Ward 6-67)

2-FULL NAME John R. E. Mc Grath

(a) RESIDENCE NO. 604 Edgewood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17 1888

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	39	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER John J. McGrath

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Agnes Reardon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) West. Va.

14 Informant John J. McGrath

(Address) 626 St Paul St.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) One day

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Stratton (Coroner)

Nov 4, 1927 (Address) Eastern Ave

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral Cem. Nov 7th 1927

20 UNDERTAKER John Hoover & Son. ADDRESS 901 Hollins St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27148

CERTIFICATE OF DEATH.

74-601

74 E 27148

1-PLACE OF DEATH

City of BALTIMORE: (No. 612 Mc Cabe Ave. Ward 27-46)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Weaver.

(a) RESIDENCE NO. 612 Mc Cabe Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widow.

5a If married, widowed, or divorced (or) WIFE of Late Charles Weaver.

6 DATE OF BIRTH (month, day, and year): Dec. 9th 1850

7 AGE: Years 76. Months 10 Days 25 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER John W. Grim

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Anna Clark.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Mrs. Anna M. Grim

(Address) Winchester Catonsville Md

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 4th 1927.

17 I HEREBY CERTIFY, That I attended deceased from 10/20/ 1927, to 11/4/ 1927, that I last saw h[er] alive on 11/4/ 1927, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) mths yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 5 hrs mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Leonard P. Fong, M. D.

11/5/ 1927 (Address) 110 W. Cold

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Hebron. Winchester Va. Date of Burial Nov. 7th 1927.

20 UNDERTAKER John J. Cowan & Son. ADDRESS 901 Holbrook St.

C. HERBERT JONES, M. D.

1927

RPH

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2074 15 27149

CERTIFICATE OF DEATH.

T 154-001 B. 27149

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7-9 ..... WARD)

2-FULL NAME Clara THOMAS

(a) RESIDENCE NO. CHAMP - Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-29-27

7 AGE: Years 0 Months 4 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER EDGAR THOMAS

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Clara Bloodsmith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record. (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1927, to Nov. 5, 1927, that I last saw h[illegible] alive on Nov. 5, 1927, and that death occurred, on the date stated above, at 9.50 A m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct. 28 1927

Was there an autopsy? Yes, Limited to the Head

What test confirmed diagnosis? Clinical & operation

(Signed) Chas Kopelman M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Deal's Island Md — DATE OF BURIAL Nov 8 1927

UNDERTAKER Stughes & Jones Inc — ADDRESS Det. of Bodies

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27150 — REGISTERED NO. E 27150

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 9-9 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claude Stewart

(a) RESIDENCE No. Glenwood Ind ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-11-07

7 AGE — Years: 20 — Months: 6 — Days: 24 — If LESS than 1 day, hrs or min.: 25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student J. Hopkins

(b) General nature of industry, business, or establishment in which employed (or employer): University

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ind -

PARENTS

10 NAME OF FATHER Thomas Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind -

12 MAIDEN NAME OF MOTHER Hattie Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Parents (Address): Johns Hopkins Hospital

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1927, to Nov 5, 1927, that I last saw him alive on Nov 5, 1927, and that death occurred, on the date stated above, at 6.25 a.m.

The CAUSE OF DEATH* was as follows:

Acute meningitis, pneumococcic

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal fluid culture

(Signed) Cleveland Flosser, M. D.

11-5, 1927 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem.

DATE OF BURIAL: Nov 7, 1927

20 UNDERTAKER: Easton Sons

ADDRESS: Elliott City

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27151

CERTIFICATE OF DEATH.

57 E 27151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 E Hoffman St.; 8-17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Estell Tippett

(Residence in Baltimore: No. 1512 E Hoffman St.; 13 years in city yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, ~~WIDOWED~~, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct ~~Nov~~ (Month) 2 (Day) 1874 (Year)

7-AGE, 33 yrs. 1 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Washington D. C.

PARENTS.

10-NAME OF FATHER, Charles Wooden

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER Rebecca Hall

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Francis Tippett

(Address) 1512 E Hoffman

15-

Filed ....., 191.... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 5 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1927 to Nov-4 1927.

that I saw h alive on 191

and that death occurred, on the date stated above, at 3.40 p.m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. mos. ds.

(Signed) W. G. Updegraff M. D.

Nov 5, 1927 (Address) 1305 N. Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL, Glenwood Cemetery — DATE OF BURIAL, Nov 8, 1927

20-UNDERTAKER, Washington Ave — ADDRESS, [illegible]

Robt J Turner Sr 44 N Broadway

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27152

CERTIFICATE OF DEATH.

161-00 E 27152

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 15-58 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Hyman

(a) RESIDENCE NO. 3723 Towanda Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White (Jewish)	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
Nov. 4 - 1927

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Hyman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Rae Farber

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant

(Address)

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Nov. 5 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1927, to Nov. 5, 1927, that I last saw h.im alive on Nov. 5, 1927, and that death occurred, on the date stated above, at 12:20 p m.

The CAUSE OF DEATH* was as follows:

Intra cranial Hemorrhage

(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Spina puncture

(Signed) Wm Schuman, M. D.

Nov 5, 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 11/6 1927

20 UNDERTAKER — ADDRESS

Hebrew Friendship Cem — Jack Levin 39 E Lex St

Spec.—1-12-23—M&T—500 Bks.

E 27153 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1017 E Lombard St. (WARD) 25

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Fox

(a) RESIDENCE NO. 1017 E. Lombard St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael Fox

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE Years 68 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 Eastern Ave

15 Filed ___ 19___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29th, 1927, to Nov. 5th, 1927, that I last saw her alive on Nov. 5th, 1927, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ___ yrs. ___ mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. T. Nicholson, M. D.

Nov 5, 1927 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herbert Memorial — DATE OF BURIAL Nov 7 1927

20 UNDERTAKER Jack Lewis — ADDRESS 1439 Eastern Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27154

CERTIFICATE OF DEATH.

179 E 27154

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Eagle Street ST.) (WARD)

2-FULL NAME Benj Berman

(a) RESIDENCE No. 2020 Eagle St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Berman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sophie Meisenkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1929 Eastern Ave

15 Filed ____ 19 ____ C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 3rd, 1925, to Nov 5th, 1927, that I last saw him alive on Nov 4th, 1927, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Decalcification of the Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Maurice Friedenwald, M. D.

, 19 (Address) 2225 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehoeth Cemetery

DATE OF BURIAL Nov 7 19 27

20 UNDERTAKER Jack Levis 1929 Eastern Ave

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27155 — 112 — E 27155

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 1142 1/2 McElderry St St. 6-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Temple

(a) RESIDENCE NO. 1142 1/2 McElderry St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Temple

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Fields

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Clara Nelson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant John Temple

(Address) 1142 1/2 McElderry St

15 Filed....., 19.... C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4/27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Indigestion

(duration) .....yrs. .....mos. 0 ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Collier M. D.

(Coroner)

1/5/27 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Calvary Cem 11/6 1927

20 UNDERTAKER Byron & Wright ADDRESS 1218 McElderry St

Spec.—1-10-21—M&T—1500 Bks.

E 27156 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27156

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 809 Hanover ST. 22-31 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Fendall

(a) RESIDENCE NO. 809 Hanover ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah Fendall

6 DATE OF BIRTH (month, day, and year) July 2 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5 5	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) Bak

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Thomas F Fendall

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Annie Tilman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Sarah Fendall
(Address) 809 Hanover

15 Filed ..... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 1 1927 to Nov 3 1927.

that I last saw him alive on Nov 3 1927

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L Pharmer M. D.

(Address) 605 Shaw ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary — DATE OF BURIAL Nov 1 1927

20 UNDERTAKER R. L Parham — ADDRESS 1216 E. Shaft

Spec.—1-12-23—M&T—500 Bks.

E 27157 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 114 E 27157

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sarah M. Paul ST. 14-20 (WARD)

REGISTERED NO. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ✓64 Wilson St

(a) RESIDENCE NO. ✓64 Wilson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James M. Paul

6 DATE OF BIRTH (month, day, and year) 1849-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Australia

14 Informant ✓ Thos E. Peters

(Address) ✓67 Wilson St

15 Filed , 19 RMK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/4/27

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18th, 1927, to Nov. 4th, 1927, that I last saw h[er] alive on Nov. 30, 1927, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Infirmities of Age

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

11/4/27 (Address) 924 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Nov 6th 1927

20 UNDERTAKER Nuttall Burton ADDRESS 916 Mc

Spec.—1-12-23—M&T—500 Bks.

E 27158 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27158

CERTIFICATE OF DEATH. 179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Perry ST., 22 WARD) 12320

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Elizabeth Henson

(a) RESIDENCE NO. 111 Perry ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (HUSBAND of ~~(or) WIFE of~~): John Henson

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years: 31; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Factory work

(c) Name of employer: Mr Folks

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Small

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: John Henson

(Address): 111 Perry St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/4/1927

17 I HEREBY CERTIFY, That I attended deceased from 10/8/, 1927, to 11/4/, 1927,

that I last saw her alive on 11/4/, 1927,

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Pulmonary Hypostasis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis (duration) yrs. mos. 27 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + History

(Signed) J.M. Bishop, M. D.

, 19 (Address) 709 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: NOV 6 1927

20 UNDERTAKER: Wm. H. Carton

ADDRESS 916 Eutaw

Spec.—1-12-23—M&T—500 Bks.

E 27159

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27159

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 Hunter St ST. 12-50 WARD)

2-FULL NAME Indiana Washington

(a) RESIDENCE No. 2316 Hunter St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Washington

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, —hrs or min
	38 yrs	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) House wife

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jefferson Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Blight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Richard Washington (Address) 2316 Hunter St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923, to Nov 5, 1923, that I last saw h[illegible] alive on Nov 4, 1923 and that death occurred, on the date stated above, at 3 A m

The CAUSE OF DEATH was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) G. [illegible], M. D.

19 (Address) 426 E 23d St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Nov 7 19 23

20 UNDERTAKER Henry A Eastern

ADDRESS 916 E 20 St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27160

CERTIFICATE OF DEATH.

31

E 27160

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 524 Gold St. St. 11-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Thomas Eugene Ross

(a) Residence No. 524 Gold St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	Col.	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margie Ross

6-DATE OF BIRTH (month, day and year) Mar. 10, 1882

7-AGE.	If LESS than 1 day.
45 yrs. 8 mos. 20 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Shipping Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer. London Town Clothiers

9-BIRTHPLACE (city or town) (State or Country). Balto, Md.

PARENTS.

10-NAME OF FATHER. Thomas E. Ross

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Annapolis Md.

12-MAIDEN NAME OF MOTHER. Alice Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

11- (Informant). Thos. E. Ross, Jr.

(Address). 524 Gold St.

15- Filed....., 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-4-27

17- I HEREBY CERTIFY, That I attended deceased from 10-26, 1927, to 11-4, 1927, that I last saw him alive on 11-4, 1927, and that death occurred, on the date stated above, at 11.10 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Macc Williams, M. D.

11-5-1927 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	11/6/, 1927

20-UNDERTAKER.	ADDRESS
Mrs. Geo. H. Holland	1631 Druid Hill Ave

Cor.—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66

E 27161 REGISTERED NO. E 27161

1-PLACE OF DEATH City of BALTIMORE: (No. New Hospital 11-24 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Elliott

(a) RESIDENCE NO. 1024 Madison Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Elliott

6 DATE OF BIRTH (month, day, and year)? 1883

7 AGE: Years 44 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bartender

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer: 0

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER: Clarence Elliott

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va.

14 Informant: Annie Jones

(Address): 1736 Mckulloh St.

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to his death (whether by accident, suicide or homicide, or from unknown cause or pending investigation.) on the day stated above.

The CAUSE OF DEATH* was as follows:

A C Alcoholism

Cardiac Asthenia

Nov 5/27 J C Gale M. D.

19 (Address) 1438 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial 11/6 1927

20 UNDERTAKER: Mrs. Geo. H. Holland ADDRESS: 631 Druid Hill Ave

Spec.—1-12-23—M&T—500 Bks.

E 27162 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

31

CERTIFICATE OF DEATH.

REGISTERED NO. 27162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1907 E. Chase St., 8-17 Ward)

2-FULL NAME James M. G. Sluntt

(a) RESIDENCE NO. 1907 E. Chase St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Eva Marie Drane

6 DATE OF BIRTH (month, day, and year) Apr 4/96

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	31	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector Electrical dept

(b) General nature of industry, business, or establishment in which employed (or employer) Inspecting electrical equipment

(c) Name of employer Balto. City 1056

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles Sluntt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine Coffay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Marie Sluntt (Address) 1907 East Chase

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 25, 1926, to Nov 4, 1927, that I last saw him alive on Nov 4, 1927, and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Knipp, M. D.

(Address) 4025 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 11/7 1927

20 UNDERTAKER William Cook — ADDRESS 501 Watts

Spec.—1-12-23—M&T—500 Blks.

E 27163 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27163
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 132 Montebello Terrace ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Simpson

(a) RESIDENCE No. 132 Montebello Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas M. Simpson

6 DATE OF BIRTH (month, day, and year) Oct 26 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER [illegible] McGaggart

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Thaler

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Geo. F. McGaggart
(Address) 132 Montebello Terrace

15 Filed NOV 6 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1927, to Nov 4, 1927

that I last saw he alive on Nov 4, 1927

and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Thomas Fluke M. D.

, 19 (Address) 532 E 22nd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Nov 7 1927

20 UNDERTAKER [illegible]

ADDRESS [illegible]

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27164

E 27164

CERTIFICATE OF DEATH

179

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. Lombard & Greene St. 9-5-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie C. Haggins

(a) RESIDENCE NO. 7th Street Fairfield, Maryland Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 22-1924

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	3	9 10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Burns Haggins

11 BIRTHPLACE OF FATHER (City or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Alice Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Abner Haggins

(Address) 7th St. Fairfield, Md

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 4 1927

17 I HEREBY CERTIFY, That I attended deceased from 11- 3, 1927, to 11 - 4, 1927, that I last saw h[illegible] alive on 11 - 4, 1927, and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH* was as follows:

Burns - body and face (2nd degree accidental - Clothing caught on fire while playing with matches

(duration) yrs. mos. 1 da.

CONTRIBUTORY Pneumonia (Secondary)

(duration) yrs. mos. 1 da.

18 Where was disease contrarted

If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Henry Vincent Dodson M. D.

11/7, 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemetery — Date of Burial 11/7 1927

20 UNDERTAKER: John H. Tordin — ADDRESS 1027 Druid Hill Ave

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27165

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 27165

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 Bank St. ST. 2-4 WARD)

2-FULL NAME William Wieczorkowski

(a) RESIDENCE NO. 1932 Bank St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bogumila Wieczorkowski

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Labor 040

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Ignatuis Wieczorkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Bogumila Wieczorkowski
(Address) 1932 Bank St.

15 Filed ....., 19 .... RRyll Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 19 27

17 I HEREBY CERTIFY, That I attended deceased from January 15, 19 27, to Nov. 4, 19 27, that I last saw h~~i~~m alive on Nov. 4, 19 27, and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Symptoms

(Signed) John V. Sozulichi, M. D.

, 19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus cem.

DATE OF BURIAL 19 27

20 UNDERTAKER John M Weber

ADDRESS 1813 Bank St.

CHAWSON JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

E 27166

Metzger

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-002

E 27166

REGISTERED NO.

4-25

1-PLACE OF DEATH

City of BALTIMORE: (No. 746 W. Lexington St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Glover Metzger

(a) RESIDENCE NO. 746 W. Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. / mos. / ds. How long in U. S. If of foreign birth? / yrs. / mos. / ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Metzger

6 DATE OF BIRTH (month, day, and year) Nov. 1st 1844

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	82	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Fritz Metzger

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Gehrs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Theodore L. Metzger

(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1927, to Nov. 4, 1927, that I last saw h[illegible] alive on Nov 3, 1927, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) old age

(duration) ... yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. H. Hemmeter, M. D.

19 (Address) 301 E. Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 11- 19
Cremation	
20 UNDERTAKER	ADDRESS
Louis Heeman	3[illegible] Conway

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27167

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27167

CERTIFICATE OF DEATH.

REGISTERED NO. 4-25 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Balto City Hospitals ST., WARD)

2-FULL NAME Julia Madra OR MONDRA

(a) RESIDENCE No. 125 N Green ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 41 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York State

PARENTS

10 NAME OF FATHER: Daniel Rumney

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Agnes Rhinehart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Hospital Record

(Address): Balto. City Hospitals

15 Filed , 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15 1927 to Nov. 4 1927

that I last saw h alive on Nov. 4 1927

and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma of Left Breast with Metastasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Tumor Bronchogenic

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs & Symptoms

(Signed) [illegible], M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Nov. 7 1927

20 UNDERTAKER: Lilly & Zuiles

ADDRESS: 403 S. Howard St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27168

CERTIFICATE OF DEATH

+9

REGISTERED NO. E 27168

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Belt

(a) RESIDENCE NO. 2017 Jefferson St. Ward F

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June 21, 1916

7 AGE: Years 11 Months 4 Days 11 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Andrew Belt

11 BIRTHPLACE OF FATHER (City or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Margaret Fahey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md

14 Informant: Mother

(Address): 2017 Jefferson St.

15 Filed ..... 19 .....

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11 - 2 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 31st, 1927, to Nov 2nd, 1927, that I last saw h[illegible] alive on 11 - 2 1927 and that death occurred, on the date stated above, at 11.43 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of cerebellum

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Increased intracranial pressure

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-1-27

Was there an autopsy?

What test confirmed diagnosis? Clinical signs

(Signed) [illegible] M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Nov 7 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 4032 Woodland Ave

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

20 3/137 E 27169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 E 27169

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 19-27 ST., WARD)

2-FULL NAME George Keith

(a) RESIDENCE No. 1210 East Franklin ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Dead

6 DATE OF BIRTH (month, day, and year) 6-23-82

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) OHO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Henry Keith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Hattie ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1927

17

I HEREBY CERTIFY, That I attended deceased from November 3, 1927, to November 4, 1927, that I last saw h living alive on November 4, 1927, and that death occurred, on the date stated above, at 9:45 p m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Raymond Wing, M. D.

11-5, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	11-8 1927
20 UNDERTAKER Joseph A. Lively	ADDRESS 401 N Mount st

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

F 27170 — 151 — F 27170

1. PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. Balto City Hospital St. 11-27 WARD)

2-FULL NAME James Thomas

(a) RESIDENCE No. 2442 N Mount ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-23 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	34	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Chas Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Emma Thomas
(Address): 2442 Mount Street

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from 6-21-, 1927, to Nov. 3, 1927, that I last saw him alive on Nov. 3, 1927, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Thrombosis Gangrene (Right Popliteal) Right foot & leg (non diabetic)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-27-27

Was there an autopsy? no

What test confirmed diagnosis? Operation & Pathological Exam

(Signed) M Blaycock, M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — DATE OF BURIAL: 11-7-1927

20 UNDERTAKER: Joseph A Lively — ADDRESS: 409 N. Mount Street

Spec.–7-17-26—A Co.—200 Bks.

E 27171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002 E 27171

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE. (No.) Maryland Gen Hosp St. 13-57 Ward

2-FULL NAME Baby Lawrence J. Baldwin

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1818 Hadwood St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Baby)

6 DATE OF BIRTH (month, day, and year) 4-17-27

7 AGE Years — Months 6 Days 18

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER T. R. Baldwin

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Ford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Hosp. Records.

(Address)

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-4-27 19

17 I HEREBY CERTIFY, That I attended deceased from 10-31-27, 19..... to 11-4-27, 19.....

that I last saw h[illegible] alive on 11-4-27, 19.....

and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows: Cholerosepticus

CONTRIBUTORY (Secondary) Cholera (duration) 1 yrs. mos. 10 ds.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 10-31-27

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) Md. Gen Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

G. Mans Hampden Nov. 7 19 27

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Falls Rd

Very important. See instructions on back of certificates.

[illegible] - 1927 C. [illegible] JONES, M. D.

Dec [illegible] Ralph

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

27172

E 27172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital 25-12 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Stonesifer

(a) RESIDENCE NO. Clear Spring Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 5 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Wh.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
61	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Samuel Stonesifer

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Pa

14 Informant Samuel Stonesifer

(Address) Clear Spring

15 Filed _____, 19 _____, Registrar

Per _____

1927 HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5 1927

17

I HEREBY CERTIFY, That I attended deceased from 10-31, 1927, to 11-5, 1927, that I last saw him alive on 11-5, 1927, and that death occurred, on the date stated above, at 1.25 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas. with Metastasis to Liver

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Postoperative Myocardial Insufficiency - Chronic Nephritis (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? yes. Date of 11-3-27.

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & Surgical

(Signed) A.J. Knapp, M. D.

11-5, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clear Spring Md Date of Burial 11-8-27.

20 UNDERTAKER Lenard Snyder ADDRESS Clear Spring Md.

Spec.—1-12-23—M&T—500 Blks.

E 27173.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27173

CERTIFICATE OF DEATH.

B 22615

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 510 N. Arlington Ave (ST.) (WARD) 18-26

2-FULL NAME Katherine Stubbs

(a) RESIDENCE No. 510 N. Arlington Ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): February 15 1839

7 AGE — Years: 88 — Months: 3 — Days: 23 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk Va

PARENTS

10 NAME OF FATHER: Simon D. Stubbs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Shepherd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs. Stubbs

(Address) 3810 Powhatan Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6th 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 15, 1927, to Nov 6th, 1927, that I last saw h[er] alive on Nov 3rd, 1927, and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Fracture right hip - bed sore on sacrum.

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Chronic valvular heart disease

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Frederick U. Scrivener M. D.

Nov 6, 1927 (Address) Relay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 7 1927

20 UNDERTAKER: J. E. Pudwill Sons — ADDRESS: Baltimore

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27174 E 27174

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd ST., 17-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Albert Curtis Walker

(a) RESIDENCE NO. Greenville ST. WARD S. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emily Howard

6 DATE OF BIRTH (month, day, and year): Dec. 1, 1882

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
45	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cotton Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Columbia Alabama

PARENTS

10 NAME OF FATHER: Robt. H. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alabama

12 MAIDEN NAME OF MOTHER: Ella Hays

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Alabama

14 Informant: Hospital Record

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1927, to Nov. 5, 1927, that I last saw him alive on Nov. 5, 1927 and that death occurred, on the date stated above, at 5:40 P m

The CAUSE OF DEATH* was as follows:

Duodenal ulcer

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Cerebral accident - probably thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? Yes Date of Nov. 5, 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) R. E. Sellers, M. D.

Nov 6, 1927 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenville S C. DATE OF BURIAL: Nov 7 1927

20 UNDERTAKER: H. Kennedy Sons Co. ADDRESS: Cleveland Ave-College

Spec.—12-9 25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27175

CERTIFICATE OF DEATH.

E 27175

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital.

City of BALTIMORE: (No. St Agnes St., 7-54 Ward)

2-FULL NAME John Finn.

(a) RESIDENCE NO. 2 Belvedere Ave Washington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary L. (nee McSweeney)

6 DATE OF BIRTH (month, day, and year) April 14, 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lamplighter P.R.R.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Mathew Finn.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs Mary Finn.

(Address) 2 N Belvedere Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-12-27, to 11-4-27, 1927, that I last saw him alive on 11-4-27, 1927, and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Esophagus

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) A J Knapp, M. D.

11-4, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New Cathedral Cem	Nov. 7 1927

20 UNDERTAKER Harry H. Metzke ADDRESS 1531 N. Fremont Ave

Key Number. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27176

CERTIFICATE OF DEATH.

66 E 27176

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 613 N Calvert St. 11-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. Kleman

(a) RESIDENCE NO. 613 N Calvert St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 3/10/1867

7 AGE: Years 40 Months 7 Days 25 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Jas Kleman

(Address) 627 Oswald St

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 5-27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Jas Kleman

(duration) 2 yrs. .....mos. .....ds.

Nov 5 19 27 (Signed) W. T. Dorsey (Coroner) M. D.

(Address) 1029 Bunsel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....d.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: S. Baltimore Cemetery — Date of Burial: N 8 1927

20 UNDERTAKER: Albert J. Hiltz — ADDRESS: 1606 N Chester St

Spec.—1-12-23—M&T—500 Blks.

E 27177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 E 27177

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospitals ST. 17-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustine Boss

(a) RESIDENCE No. 515 N. Fremont ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Single~~

6 DATE OF BIRTH (month, day, and year) Mar 4 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER John Holiday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Hospital Records (Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1927, to Nov. 3, 1927

that I last saw her alive on Nov. 3, 1927

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

Pelvic Peritonitis.

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab findings

(Signed) Blugood M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lawnview Park

DATE OF BURIAL 11/7 1927

20 UNDERTAKER George Ruth ADDRESS 1730 Hanford

Spec.—12-9-25—A Co.—200 Bks.

E 27178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 27178

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 662 W. Saratoga St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gaspero Marino

(a) RESIDENCE NO. 662 W. Saratoga St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white.

5 Single, Married, Widowed, or Divorced. (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Marino

6 DATE OF BIRTH (month, day, and year): May 3rd 1883

7 AGE: Years 44 | Months 6 | Days 1 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): Self. 045

(c) Name of employer

9 BIRTHPLACE (city or town): Italy

(State or country)

PARENTS

10 NAME OF FATHER: Angelo Marino

11 BIRTHPLACE OF FATHER (city or town): Italy

(State or country)

12 MAIDEN NAME OF MOTHER: Salvatora di Fina

13 BIRTHPLACE OF MOTHER (city or town): Italy

(State or country)

14 Informant: Frankie Fenia

(Address) 3059 Brighton St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Nov, 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 2nd 1927, to Nov. 4th, 1927, that I last saw him alive on Nov 4th, 1927, and that death occurred, on the date stated above, at 2.35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemic Convulsion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary Test

(Signed) H. J. Carrick, M. D.

, 19 (Address) 3709 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Nov 7 1927

Date of Burial

20 UNDERTAKER: Geo. F. Ruth

ADDRESS 1735 Harford Av.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20E 27179 — 154 E 27179

1-PLACE OF DEATH: JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lois Groves

(a) RESIDENCE NO. Waldorf Md. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2-10-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	—	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Joseph Groves

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maude Burdett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant ..... (Address) .....

15 Filed ..... 19 ..... RPH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1927, to Nov. 6, 1927, that I last saw h alive on Nov. 6, 1927, and that death occurred, on the date stated above, at 6.30 + m.

The CAUSE OF DEATH* was as follows:

Mental retardation + congenital cerebral malformation

since birth (duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Related complications

since birth (duration) yrs. 7 mos. 6 ds.

18 Where was disease contracted if not at place of death? Since birth

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Eye exam + x-ray

(Signed) J. C. Goodwin, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newport Md	11/ 1927

20 UNDERTAKER Geo. C. Turley ADDRESS Salem & Fayette

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27180

CERTIFICATE OF DEATH

24-001

E 27180

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3401 Greenway St. 12-41 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Clarence Jones Grieves

(a) RESIDENCE NO. 3401 Greenway St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ? mos. ? ds. How long in U. S. if of foreign birth? 59 yrs. 0 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Ramsay Grieves

6 DATE OF BIRTH (month, day, and year) October-23-1868

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	59	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer) Dentistry

(c) Name of employer Self

9 BIRTHPLACE (city or town) Wilmington

(State or country) Delaware

PARENTS

10 NAME OF FATHER Edward Weldin Grieves

11 BIRTHPLACE OF FATHER (City or town) Wilmington

(State or country) Delaware

12 MAIDEN NAME OF MOTHER Lucretia Jones

13 BIRTHPLACE OF MOTHER (city or town) Wilmington

(State or country) Delaware

14 Informant Mrs. Hannah Ramsay Grieves (wife)

(Address) 3401 Greenway

15 Filed ..... 19 .....

Registrar

Per R.R.Reg

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

November 4 1927

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 19, to Nov 4, 19 27.

that I last saw h[illegible] alive on Nov 4, 19 27.

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(death in 15 minutes from onset)

..... (duration) ....yrs. ....mos. ....da.

CONTRIBUTORY Arterio-Sclerosis
(Secondary)

Many

..... (duration) ....yrs. ....mos. ....da.

18 Where was disease contracted

if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Hemiplegia - 4 yrs ago

(Signed) Sydney Kitmiller, M. D.

11/5, 1927 (Address) 1115 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Greenmount Cemetery	Nov-7-27 19
20 UNDERTAKER	ADDRESS
J. HENRY & MOWEN COMPANY (Successor)	106 W. NORTH AVE.

Very Important. See instructions on back of certificates.

NOV 7 1927 [illegible]

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27181
1-PLACE OF DEATH

45 ✓

15-62

REGISTERED No. E 27181

City of BALTIMORE: (No. 3401-Copley Road. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kellye May Carney

(a) RESIDENCE NO. 3401-Copley Road. St. Ward Resident
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 11 mos. 3 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Henry Carney

6 DATE OF BIRTH (month, day, and year) December-2-1867

7 AGE	Years	Months	Days
	59	11	3

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 37
(b) General nature of Industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Schmidt

11 BIRTHPLACE OF FATHER (City or town) ? ?
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Scott

13 BIRTHPLACE OF MOTHER (city or town) ? ? ?
(State or country) England

14 Informant Mr. James K. Carney (son)
(Address) 3438-University Place, City

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 5 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to November 5, 1927, that I last saw h.. alive on November 5, 1927, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Gemal Carcinosis

(duration) dr 4 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of July 1. 27.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas O'Donovan M. D.

Nov 6, 1927 (Address) 5 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — Date of Burial Nov-8-27 19

20 UNDERTAKER STEWART & WOODEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27182

CERTIFICATE OF DEATH.

11 ✓ E 27182

REGISTERED No.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Carl A. Magnuson

(a) RESIDENCE No. 1708 Friendsbury St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Magnuson

6 DATE OF BIRTH (month, day, and year): July 21 1862

7 AGE: Years 65 Months 3 Days 13 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watch maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant (Address): Anna Magnuson 1708 Friendsbury

15 Filed NOV 7 - 1927 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 4 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1927, to Nov 4, 1927, that I last saw him alive on Nov. 4, 1927 and that death occurred, on the date stated above, at 1.35 P m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis with general peritonitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 2, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Operation, Physical examination etc

(Signed) J. Frank Hewitt, M. D.

Nov 4, 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: Nov 7 1927

20 UNDERTAKER: Wendell Dyffel & Son

ADDRESS: 37 S Mon

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 27183

REGISTERED NO.

E 27183

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 N. Hare ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhimenia Moran

(a) RESIDENCE NO. 23 N. Hare St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John P. Moran

6 DATE OF BIRTH (month, day, and year) Sept. 4 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ....min.
	34	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Frank Buttner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Huff.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Frank Buttner 23 N. Hare St

Filed NOV 7 - 1927 19 H. H. HAMILTON, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 29 19 27 to Nov. 3 19 27

that I last saw her alive on Nov 3 19 27

and that death occurred, on the date stated above, at 3.08 P. m.

The CAUSE OF DEATH* was as follows:

Ch parenchymatous nephritis — Mitral & aortic insufficiency Hypertension

(duration) 2 yrs. + mos ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. data

(Signed) Leo Schlenger M. D.

19 (Address) 3034 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov. 7 1927

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St.

Spec.—12-9-25—A Co.—200 Bks.

Cassady

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27184

CERTIFICATE OF DEATH.

× 90

E 27184

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 703 W Baare St. 11-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME S Emily Cassady.

(a) RESIDENCE NO. 703 W Baare St. Ward Fork Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Cassady

6 DATE OF BIRTH (month, day, and year): May 7 1854

7 AGE: Years 73 | Months 5 | Days 24 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of indnstry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: John Baer

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Adele Clayton

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Mr Annie Ritter

(Address) 703 Baare St

Filed 7-1927 By

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 11/3/27

17 I HEREBY CERTIFY, That I attended deceased from 8/31, 1927, to 11/3/, 1927,

that I last saw h.. alive on 11/3/, 1927,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Bernard J. Jung, M. D.

11/5/1927 (Address) 916 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fork M.E. Cemetery Date of Burial Nov 7 1927

20 UNDERTAKER: Clarence E Arthur ADDRESS: Fork Md

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 27185 HEALTH DEPARTMENT—CITY OF BALTIMORE

57

CERTIFICATE OF DEATH.

REGISTERED NO. E 27185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 21-69 WARD)

2-FULL NAME Simon Smith

(a) RESIDENCE No. 2118 Penrose ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Carrie Smith

6 DATE OF BIRTH (month, day, and year) Jan. 13 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hat Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn, N. Y.

PARENTS

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Jos. Smith (Address) 2118 Penrose Ave

15 Filed NOV 7 - 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5/27 19

17

I HEREBY CERTIFY, That I attended deceased from 10/1/27, 19, to 11/5/27, 19,

that I last saw h[illegible] alive on 11/5/27, 19,

and that death occurred, on the date stated above, at 1 00 P.M. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of Left Leg

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/19/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Whitead, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohel Shalom Cem. DATE OF BURIAL 11/7/1927

20 UNDERTAKER Herd Sondheim ADDRESS 115-20 W. Mt. Royal Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 27186

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27186

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1905 N. Bentalou ST. 15-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Steidner

(a) RESIDENCE. NO. 1905 N. Bentalou ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22nd 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Vendon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George E. Steidner
(Address) 1905 N. Bentalou St

15 NOV 7 - 1927 Registrar HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927, to Nov 3, 1927, that I last saw her alive on Nov 3, 1927, and that death occurred, on the date stated above, at 10A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma, heart failure, Senility

(duration) ? yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) arterio Sclerosis heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Nellie Hall Cox, M. D.

, 19 (Address) 2201 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 8 1927
20 UNDERTAKER	ADDRESS
Frank Conder	1617 Eutaw Pl

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27187

CERTIFICATE OF DEATH

74-001

E 27187 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3707 Laurello Ave St. 20-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Heldmann

(a) RESIDENCE NO. 3707 Lauretta Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia K. Heldmann

6 DATE OF BIRTH (month, day, and year) Aug 20 - 1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	72	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 12 years

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Heldmann

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Von Eschwege

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Julia K. Heldmann

(Address) 3707 Lauretta Ave

15 Filed NOV 7 1927 19 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1927, to Nov 5th, 1927.

that I last saw him alive on Nov 4th, 1927.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Gordy M. D.

(Address) 4218 Halford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — Date of Burial Nov. 8 1927

20 UNDERTAKER Henry Sauter & Sons Inc — ADDRESS 1110 Park St.

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 27188 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-007 E 27188

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 N. Milton ave STR. 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella N. Baird

(a) RESIDENCE No. 512 N. Milton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~. (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of A Austin Baird

6 DATE OF BIRTH (month, day, and year) March 14th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Behrens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Friederica Dantor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant A Austin Baird

(Address) 512 N. Milton ave

15 Filed 7-1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4th 1927

17

I HEREBY CERTIFY, That I attended deceased from Augt - 1927 to Nov 5 1927

that I last saw her alive on Nov 4 1927

and that death occurred, on the date stated above, at 10 10 a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

CONTRIBUTORY (Secondary) Cardiac Asthenia (duration) yrs. 3 mos ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phy Ex

(Signed) G 6 3 Tables, M. D.

(Address) 143 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL Nov 6th 1927

20 UNDERTAKER George Schilling & Sons

ADDRESS N. Howard

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Bring back Burial permit

118-004

E 27189

CERTIFICATE OF DEATH

E 27189

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St., 5-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A McCabe

(a) RESIDENCE NO. 1705 W. Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth 56 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20 / 1906

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	20	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Thomas Ryan

9 BIRTHPLACE (city or town) Richmond Va

(State or country)

PARENTS

10 NAME OF FATHER James A McCabe

11 BIRTHPLACE OF FATHER (City or town) Richmond Va

(State or country)

12 MAIDEN NAME OF MOTHER Lela E Lindsay

13 BIRTHPLACE OF MOTHER (city or town) Richmond Va

(State or country)

14 Informant Lela E McCabe

(Address) 2313 E Federal St

Filed OV 7 - 1927 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 19 27, to Nov 7, 19 27, that I last saw him alive on Nov 7, 19 27, and that death occurred, on the date stated above, at 12.05 A. m.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia
Intestinal Obstruction

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Tumour

(duration) yrs. mos. 7 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? Yes Date of 10-5-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Laurence Fahrney, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Cem	Nov 9 19 27
20 UNDERTAKER	ADDRESS
William Lee	2026 Madison

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 27190

1-PLACE OF DEATH E 27190

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1233 S. Decker ave. ST. 1-7 WARD)

2-FULL NAME Catherine Zembrowska.

(a) RESIDENCE No. 362 S Robinson st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Frank Zembrowski

6 DATE OF BIRTH (month, day, and year): Oct 9 1881

7 AGE: Years 46 Months — Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Spouse Wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: Barton Piechowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Antonina Kluzynska (Address) 362 S. Robinson st.

15 Filed NOV 7 - 1927 HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6 1927

17 I HEREBY CERTIFY, That I attended deceased from September 1, 1927 to November 6, 1927, that I last saw h[illegible] alive on November 6, 1927, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis & Arteriosclerosis

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Engelbrecht, M. D.

, 19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem nov 8 1927

DATE OF BURIAL

20 UNDERTAKER: George A Weber. 2205 Bank st

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27191

CERTIFICATE OF DEATH.

E 27191

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Burgundy ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John K. Anderson

(a) RESIDENCE NO. 924 Burgundy ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	9	19	

8 OCCUPATION OF DECEASED general labor

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) around water front

(c) Name of employer to self

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo. H. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Winchester Va.

12 MAIDEN NAME OF MOTHER Rachael Kilpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Winchester Va.

14 Informant Mrs. K. Anderson

(Address) 924 Burgundy Ave.

Filed Nov 7 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 31, 1927, to Nov 3, 1927, that I last saw him alive on Nov 2, 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of upper lobe left lung.

about 10 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests.

(Signed) H. E. Knipp M. D.

11/4, 1927 (Address) 4025 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkview Cemetery DATE OF BURIAL Nov. 7 1927

20 UNDERTAKER Peter E. Cook ADDRESS 603 N. Gilmor St.

Spec.-7-17-26—A Co.—200 Bks.

E 27192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 27192

REGISTERED NO. [redacted]

1-PLACE OF DEATH

City of BALTIMORE: (No. 2624 N. Charles St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Sylvester Macneal

(a) RESIDENCE NO. 2624 N. Charles St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of James B. Macneal

6 DATE OF BIRTH (month, day, and year) May 25th, 1844

7 AGE	Years	Months	Days
	83	5	11

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Loammi Burgess

11 BIRTHPLACE OF FATHER (City or town) Hartford

(State or country) Conn.

12 MAIDEN NAME OF MOTHER Mary Jane Mann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Chas. L. Macneal of James

(Address) 305 E. 22nd St.

Filed NOV 1 - 1927 19 C. HARRISON JONES, M. D. Registrar

Per [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

November 3, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1927, to Nov 3 1927, 19....., that I last saw her alive on Nov 3 1927, 19....., and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) yrs. 6 Weeks mos. ds.

CONTRIBUTORY (Secondary) Age & Chronic Interstitial Nephritis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A. Evans, M. D.

11/5. 1927 (Address) 612 W. 40th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	11/7/27 19

20 UNDERTAKER Howard Cook

ADDRESS 1093 W. Baltimore St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27193

CERTIFICATE OF DEATH.

74-001

E 27193

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Keefe

(a) RESIDENCE No. Mt Hope Retreat ST., 28th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May (?) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	74 or 75 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer) Dress goods

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York city N.Y.

PARENTS

10 NAME OF FATHER Mathew Keefe

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland -

12 MAIDEN NAME OF MOTHER Bridget Cody

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland -

14 Informant Records of Mt Hope (Address) Mt Hope Retreat

15 Filed 7-1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 26 1894, 19 ... to Nov 6, 19 27, that I last saw h... alive on Nov 6, 19 27, and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows:

Paralysis - Post Cerebral Hemorrhage

abt (duration) 2 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Depr - Psychosis -

abt (duration) 33 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? New York city

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

11 6, 19 27 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York, Mt. | DATE OF BURIAL Nov. 19 27

20 UNDERTAKER [illegible] Cook | ADDRESS 1603 N Calvert St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27194

CERTIFICATE OF DEATH.

31 E 27194

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto City Hosp. ST. 6-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Brown

(a) RESIDENCE NO. 2223 Carlisle Place STREET WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---- mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charleston S.C. S.C. Carolina

PARENTS

10 NAME OF FATHER B. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER A. Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records (Address) Balto City Hosp.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 16 1927 to Nov 5 1927

that I last saw him alive on Nov. 5 1927

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) S. C. McFadden M. D.

11/5 1927 (Address) Balto City Hospital.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn

DATE OF BURIAL Nov 8 1927

20 UNDERTAKER Ralph Williams

ADDRESS 1515 E Fayette St

Spec- 12-23-21- E.B.R.S.—400 Bks.

Martha B Dockett.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27195

CERTIFICATE OF DEATH.

129 E 27195

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1215 Druid Hill ave St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Martha Ann Dockett

(a) Residence No. 1215 Druid Hill ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Negro	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John O Dockett

6-DATE OF BIRTH (month, day and year) Dec 24-1868

7-AGE.	If LESS than 1 day.
58 yrs. 11 mos. 11 ds. 3	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 37
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Lexington
(State or Country), Ky.

PARENTS.

10-NAME OF FATHER, Henry Slaughter

11-BIRTHPLACE OF FATHER (city or town)..... Lexington
(State or Country), Ky

12-MAIDEN NAME OF MOTHER, Josephine Read

13-BIRTHPLACE OF MOTHER (city or town)..... Lexington
(State or Country), Ky

14-(Informant) John O. Dockett
(Address) 1215 Druid Hill Ave

15-

16-

NOV 7 - 1927

C. HAMPSON JONES, M. D.

Per .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 3rd 1927

17- I HEREBY CERTIFY, That I attended deceased from Sept 3rd 1927 to Nov 3rd 1927 that I last saw h.r alive on. November 2nd 1927 and that death occurred, on the date stated above, at 3-P- m. The CAUSE OF DEATH* was as follows:

Paremetymotomous rupture

(Duration)..... yrs. 9 mos..... ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration)..... yrs..... mos. 3 ds.

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No Symptoms etc.

What test confirmed diagnosis? Clinical findings

(Signed) L. Burnell Fargo M. D.

, 19 (Address) 2937 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Nov 7 1927
20-UNDERTAKER	ADDRESS
Mrs R.G. Elliot	225 Saloon

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27196

CERTIFICATE OF DEATH.

90

E 27196

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Lakeman St near Paca St Ward)

2-FULL NAME Joseph M. Tarbutton

(a) RESIDENCE NO. 416 Gittings St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. da.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Delma Tarbutton

6 DATE OF BIRTH (month, day, and year): Sept 13 1900

7 AGE — Years: 27 — Months: 1 — Days: 21 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto City

9 BIRTHPLACE (city or town): St. Michaels

(State or country): Md

PARENTS

10 NAME OF FATHER: Samuel Tarbutton

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Eaton

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Delma Tarbutton

(Address): 416 Gittings St

15 Filed: NOV 7-1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 4 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, and from autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Nov 6 1927 (Signed) Wm. Fox Norton M. D. (Coroner) (Address) Curtis Bay Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: 11/7 1927

20 UNDERTAKER: J. M. Cook — ADDRESS: 502 E Monument

very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27197.

101-001

E 27197

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1850 McHenry St. 19-28 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie L Fine

(a) RESIDENCE NO. 1850 McHenry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Fine

6 DATE OF BIRTH (month, day, and year): May 30 1888

7 AGE: Years 39 Months 5 Days 15 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Robert L Johnson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary B. Mayo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bath Me

14 Informant: Lucy Finley

(Address): 426 N Gilmor St

15 Filed: V 1-1927

C. HAMPSON JONES, M. D. Registrar

Per RLH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 5 1927

Nov-5-1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1927, to Nov 5, 1927, that I last saw h alive on Nov 3, -, 1927, and that death occurred, on the date stated above, at 5-5-5 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary): Pneumonia (Lobar)

(duration) - yrs. - mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bauman Stood, M. D.

11/5, 1927 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

Date of Burial: Nov 8 1927

20 UNDERTAKER: [illegible] Cook

ADDRESS: 502 E Monument

very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

27198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× H E 27198

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Ramsay ST.) 20-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Villium Hirsch

(a) RESIDENCE. No. 10 Hoffman Ave ST. Landover Md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Marie Fangman Hirsch

6 DATE OF BIRTH (month, day, and year) 11 Dec 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) (Retired)
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Nor Bremen, Germany

PARENTS

10 NAME OF FATHER Fred Hirsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nor Bremen, Germany

12 MAIDEN NAME OF MOTHER Charlotta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nor Bremen Germany

14 Informant Fred Wm Hirsch
(Address) Landover md

15 Filed 19 C. HAMPSON JONES, M. D., Registrar
T - 1927 - Per RHJ

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 Nov 1927

17 I HEREBY CERTIFY, That I attended deceased from 23 Oct, 1927, to 5 Nov, 1927, that I last saw h— alive on 5 Nov 1927 and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Landover Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) [illegible] M. D.
5 Nov '27 (Address) Landover Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer	Nov 9 1927
20 UNDERTAKER George J Smith	ADDRESS 1332 Hollins

Spec.—1-12-23—M&T—500 Bks.

E 27199 ✓ E 27199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 8-17 (WARD)

2-FULL NAME Frank Karmann

(a) RESIDENCE NO. 1714 E. Aliceanna ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Anna Karmann

6 DATE OF BIRTH (month, day, and year) May 29. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	51	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 80

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Karmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Karmann (Address) 1714 E. Aliceanna St

15 Filed NOV 7 - 1927 C. HAMPSON JONES, M. D. Registrar Per RRR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1927, to 11-6-27, 19

that I last saw him alive on 11-6-27, 19

and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio-vascular Disease

& Auricular Fibrillation

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy findings

(Signed) M Robertson, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dale Cemetery

DATE OF BURIAL Nov 9 1927

UNDERTAKER Ralph Turner Inc

ADDRESS 1727 N. Bway

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27200

CERTIFICATE OF DEATH.

100-001

E 27200

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 337 N. Calhoun St. 19-7b Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Simms

(a) RESIDENCE NO. 337 N. Calhoun Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0/1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Cold	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 25th 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	—	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Simms

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Chaney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Wm Simms

(Address) 337 N. Calhoun St

15 Filed Nov 7 1927 HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

Nov 6 1927 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt Zion Cemetery — Date of Burial Nov 7 1927

20 UNDERTAKER — Lattie Gross — ADDRESS 1405 McElderry

Very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27201

CERTIFICATE OF DEATH

101-001

E 27201

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Gross Sr.

(a) RESIDENCE NO. 720 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John J. Gross

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant

(Address) Relative

15 Filed NOV 7 - 1927 Registrar

CHARLES JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5/ 1927.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1927. to Nov. 5, 1927.

that I last saw him alive on Nov. 5, 1927.

and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) C. Holmes Gross, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert County Md. Date of Burial 1927

20 UNDERTAKER Lattie Gross ADDRESS 1405 E. Monument

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27202 E 27202

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5723 (Street) Registertown Rd (WARD) 21-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Merriam

(a) RESIDENCE NO. 643 (Street) Washington Blvd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed.

5a If married, widowed, or divorced (HUSBAND of or) WIFE of R. W Merriam

6 DATE OF BIRTH (month, day, and year) Sept 15/84

7 AGE 83 Years 1 Months 20 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland.

PARENTS

10 NAME OF FATHER Wm Kinnoor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) Miss Rachel Merriam 643 Washington Blvd

15 Filed NOV 7 - 1927 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 1927 to Nov 4th 1927 that I last saw her alive on Nov 24th 1927 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Coronary Disease

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis. Chronic

(duration) Unknown ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Syncope; Bl. Pr.

(Signed) Bradycardia Edw. E Parker M. D.

1927 (Address) 3123 St. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL Nov 8 1927

20 UNDERTAKER Jos Jourdenay + Son ADDRESS 217 S. Paca St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27203

CERTIFICATE OF DEATH.

×97-002
E 27203

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mayo T. Frye

(a) RESIDENCE NO. Canon Springs, W. Va. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) W. Va.

PARENTS

10 NAME OF FATHER Benjamin Frye

11 BIRTHPLACE OF FATHER (city or town)

(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Jennie Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) W. Va.

14 Informant Hopkins Hospital

(Address)

Filed NOV 7 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumococcic Meningitis with abces

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Previous Frontal Sinus Infection. (duration) 2 yrs. mos. ds.

(Signed) J. W. Walls M. D.
(Coroner)

11/7/27 (Address) 503 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Capon Bridge W. Va. Date of Burial 11-7 1927

20 UNDERTAKER E & C Earle ADDRESS 115 E West St

Very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 27204 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27204

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. University Hospital St. 26-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Sparks

(a) Residence No. 3403 Mt Pleasant Ave St. 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ George Washington Sparks

6-DATE OF BIRTH (month, day and year) Feb 23-1906

7-AGE. 21 yrs. 8 mos. 13 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS.

10-NAME OF FATHER: George Gebner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Anna Hartlove

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14- (Informant): George W. Sparks

(Address): 3403 Mt. Pleasant Ave

15- FILED NOV 1 - 1927 HAMPSON JONES, M. D. By [signature]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 11/6/27

17- I HEREBY CERTIFY, That I attended deceased from 10/23, 1927 to 11/6, 1927

that I last saw h.e alive on 11/6, 1927

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Peritonitis (general) (Acute)

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Terminal pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/24/27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. T. Hibbitts, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem. — DATE OF BURIAL: Nov 8, 1927

20-UNDERTAKER: Lilly & Zeller — ADDRESS: 433 S. Wolfe St.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27205

CERTIFICATE OF DEATH.

15 E 27205

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balt City Hospital ST. 18-26 WARD)

2-FULL NAME Louis Hall

(a) RESIDENCE No. 113 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): century

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Lewis Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant (Address): Balt City Hospital

HAMPSON JONES, M. D.

1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 3 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1926 to Nov. 3, 1927

that I last saw him alive on Nov. 3, 1927

and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis & Senile Gangrene Right foot & leg (Non diabetic)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) W. Blizard, M. D.

, 19 (Address) Balt City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Nov. 19 27
20 UNDERTAKER	ADDRESS
P. J. Brown	

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27206

100-001

CERTIFICATE OF DEATH.

E 27206

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 802 Sharp St. 27-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Mitchell

(a) Residence No. 802 Sharp St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Sept 13 1913

7-AGE. 14 yrs. 1 mos. 25 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) James M. Mitchell

(Address) 802 Sharp St

15- Filed NOV 7 - 1927 C. HAMPSON JONES, M. D. Registrar.

Per RMH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11-5-27

17- I HEREBY CERTIFY, That I attended deceased from Oct. 29 1927 to Nov 5 1927

that I last saw h.. alive on Nov 5 1927

and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus infection

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) A. H. Carroll M. D

11/7, 1927 (Address) 1329 N. Collington Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Zion	Nov 9, 1927
UNDERTAKER, G. L. Bloomstein	ADDRESS 1012 Monroe

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27207

CERTIFICATE OF DEATH.

52 E 27207

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1333 N. Carey ST., 15-23 WARD)

2-FULL NAME Howard H. Smith

(a) RESIDENCE NO. 1333 N. Carey ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or ~~WIFE of~~ Annie C. Smith

6 DATE OF BIRTH (month, day, and year) March 16 - 78

7 AGE: Years 49 Months 7 Days 20 M

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Annie C. Smith
(Address) 1333 N. Carey St

15 [illegible] - 1927 C. HAMPSON JONES, M. D. Registrar
Per R.P.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1927 to Nov 5 1927, that I last saw h[illegible] alive on Nov 5 1927, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

1) (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W. [illegible] Carr [illegible], M. D.

Address 5 S Wooster

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Nov 9 1927

20 UNDERTAKER: Sam'l W. Bowers Sons — ADDRESS: 400 Wood

FRONT—Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 27208

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 19-27, 162

City of BALTIMORE: (No. 1710 Vine St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Wilson

(a) Residence No. 1710 Vine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 10/30/27

7-AGE. yrs. mos. 4 ds. If LESS than 1 day, 9 hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, Md. (State or Country)

PARENTS.

10-NAME OF FATHER, Frank Wilson

11-BIRTHPLACE OF FATHER (city or town) Washington D.C. (State or Country)

12-MAIDEN NAME OF MOTHER, Cornelia Taylor

13-BIRTHPLACE OF MOTHER (city or town) Columbia S.C. (State or Country)

14-

(Informant)

(Address)

15-Filed - 1927

C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11/4/27

17- I HEREBY CERTIFY, That I attended deceased from 10/30, 1927, to 11/4, 1927, that I last saw h~~im~~ alive on 11/4, 1927, and that death occurred, on the date stated above, at 12.30 a m

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jno. T. Hebbeler, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, 5 19

20-UNDERTAKER, ADDRESS

Spec.—1-12-23—M&T—500 Bks.

E 27209

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27209

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 3-4 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sampson II

(a) RESIDENCE NO. 114 S Caroline ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14 27

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5 Hrs	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Nathaniel Sampson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) ?

12 MAIDEN NAME OF MOTHER Elizabeth Sampson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) .....

14 Informant Johns Hopkins Hospital
(Address) .....

15 Filed ..... 19 .....
By .....
Registrar

C. HAMPSON JONES, M. D.

7-1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1927, to Nov 2, 1927, that I last saw h alive on Nov 2, 1927, and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. 1 mos 16 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Oct 26

Was there an autopsy? Yes Exploratory - for Hydrocephalus

What test confirmed diagnosis? .....

(Signed) J. Ridgeway Trimble, M. D.

Nov 7 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27210 — 161-001 — E 27210

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1761 Mulliken St., 6-9 Ward)

2-FULL NAME Baby Bowers

(a) RESIDENCE NO. 1761 Mulliken St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 2 /27

7 AGE — Years — Months — Days — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore 11/4, 1927 (State or country)

PARENTS

10 NAME OF FATHER Charles Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lora Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Leon S. Bowers

(Address) 1761 Mulliken St

15 Filed C. HAMPSON JONES, M. D. Registrar

1927 Per ACB

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

Prima pulmonis

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) C. H. Jones M. D. (Coroner)

(Address) 508 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27211

E 27211

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 North Washington ST., 6th WARD)

2-FULL NAME Michael H. McKinley,

(a) RESIDENCE NO. 138 North Washington ST. 6th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White.	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes McKinley,

6 DATE OF BIRTH (month, day, and year) Aug. 21, 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58	—	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deputy Sheriff of Baltimore City.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md,

PARENTS

10 NAME OF FATHER Patrick McKinley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland,

12 MAIDEN NAME OF MOTHER Mary Carr,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Agnes McKinley
(Address) 138 N. Washington St.

Filed NOV 7 - 1927 19 C. HAMPSON JONES, M. D. Registrar.

Ref.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1927, to Nov. 5, 1927, that I last saw him alive on Nov. 5, 1927, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death,

Did an operation precede death? Yes, Date of May 27, 27.

Was there an autopsy? No. X-rays, etc

What test confirmed diagnosis?

(Signed) C. [illegible] M. D.

, 19 (Address) Johns Hopkins Hosp,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Nov 8 1927

UNDERTAKER J. A. Moran

ADDRESS 300 E. Baltimore.

Spec.—1-10-21—M&T—1500 Bks.

27212

HEALTH DEPARTMENT—CITY OF BALTIMORE

27212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 W. Lexington ST., 11-25 WARD) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Gregory Jung

(a) RESIDENCE NO. 410 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 9/16/1889

7 AGE: Years 38 | Months 1 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto [illegible]

PARENTS

10 NAME OF FATHER: Louis V. Jung

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Mongold

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Louis V. Jung

(Address): 410 W. Lexington

15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/7/1927

17 I HEREBY CERTIFY, That I attended deceased from 11/7/1927 to 11/7/1927, that I last saw him alive on 11/7/1927, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] Wm Lenger, M. D.

11/7/1927 (Address) 724 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn County

DATE OF BURIAL: 11/10/1927

20 UNDERTAKER: Harriman Cook

ADDRESS: SOLEMN

Spec.—1-12-23—M&T—500 Bks.

E 27213

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27213

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 Woodburne ST. 27-18 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hayne—

(a) RESIDENCE No. 600 Woodburne ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE~~ Lida Hayne

6 DATE OF BIRTH (month, day, and year) Jan. 10-1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
66	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): own

(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Fletcher Hayne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland—

12 MAIDEN NAME OF MOTHER: Ruth Gosnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland—

14 Informant: Lida Hayne

(Address) 600 Woodburne

15 Filed 7-1927 C. HAMPSON JONES, M. D. Registrar

per ..... April

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to June 5, 1927, that I last saw h[illegible] alive on June 5, 1927 and that death occurred, on the date stated above, at 6.25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage, due to Hypertrophy of Heart from Arteriosclerosis

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Auto cardiac Intestinal

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. A. Bittner, M. D.

June 6, 1927 (Address) 201 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Co—

DATE OF BURIAL: 11/6 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 5025 York Rd

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27214 E 27214

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hosp. (St.) 10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frederick Gross

(a) RESIDENCE NO. 2608 E. Baltimore ST. WARD Baltimore Md

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. F. Gross.

6 DATE OF BIRTH (month, day, and year) Oct 10 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63 64		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day-laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Gross.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Wagelli

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Gross (wife) (Address) (above.)

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1927, to Nov. 6, 1927, that I last saw h~~im~~ alive on Nov. 6, 1927, and that death occurred, on the date stated above, at 12 Am

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Myocarditis ? (duration) 1-2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) ? yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Nov. 2 1927

Was there an autopsy? No.

What test confirmed diagnosis? Macroscopic

(Signed) R. J. Bellord, M. D.

(Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem DATE OF BURIAL Nov 9th 1927

20 UNDERTAKER Peter Nicolaus ADDRESS 923 Eastern Ave

Spec.—1-12-23—M&T—500 Bks.

E 27215

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27215

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore Hospital ST. 6-11 WARD)

2-FULL NAME Peter Cordell

(a) RESIDENCE NO. 37 N Linwood Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE: Years 69 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rigger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Olaf Cordell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Lyna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Margaret Mohr
(Address) 37 N. Linwood Ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 17 1927 to Nov. 5 1927 that I last saw him alive on Nov. 5, 1927 and that death occurred, on the date stated above, at 5-15 P m.

The CAUSE OF DEATH* was as follows:

Chronic tuberculosis Myelitis. Chronic Myocarditis - Decubitus Abscess and Senile Gangrene of Left foot and leg - (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) myocardial degeneration (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Oct. 30, 1927

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) ..... M. D.

, 19 (Address) Balt City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL Nov 9th 1927

20 UNDERTAKER: Frank V. Pipiton — ADDRESS 2818 E. Balto St

Spec.—1-12-23—M&T—500 Bks.

E 27216

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St. 69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Alfred Roberts

(a) RESIDENCE NO. Westfield, N. Y. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Myra M. Roberts

6 DATE OF BIRTH (month, day, and year) June 11 - 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist — 07

(b) General nature of industry, business, or establishment in which employed (or employer) Research work U.S.A.

(c) Name of employer Government Edgewood Arsenal

9 BIRTHPLACE (city or town) (State or country) Grove N. Y.

PARENTS

10 NAME OF FATHER Edwards M. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Grove N.Y.

12 MAIDEN NAME OF MOTHER Elmira Grove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Grove N.Y.

14 Informant Myra M. Roberts wife

(Address) Westfield N.Y.

File 1927 G. HAMPSON JONES, M. D.

Par ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept 20 . 1927 . to Nov 7 . 1927 .

that I last saw him alive on Nov 7 . 1927 .

and that death occurred, on the date stated above, at 9:10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage from varicose veins of esophageal vein (duration) yrs. mos. 2 ds.

If where was disease contracted if not at place of death? At Home

Did an operation precede death? 2w Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. Hyard Jones M. D.

. 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Kirk N.Y.	Nov 7 19 27
20 UNDERTAKER	ADDRESS
Mathews & Jones Inc	414 N. Broadway

Spec.—1-12-23—M&T—500 Blks.

E 27217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27217

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 332 N. Carrollton Ave. (Ward) 8-26 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gertrude Mason

(a) RESIDENCE NO. 332 N Carrollton Ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Gilbert Mason

6 DATE OF BIRTH (month, day, and year): Feb 2 1865

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
62	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James J. Gilchrist

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Flannigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Mason

(Address) 332 N Carrollton

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6 1927

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to Nov 6, 1927, that I last saw h e alive on Nov 6, 1927, and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Cain, M. D.

11 7. 1927 (Address) 612 N 40th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary Cem — DATE OF BURIAL: Nov 9 1927

20 UNDERTAKER: J. J. Tucker, Sons — ADDRESS: Town

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27218

CERTIFICATE OF DEATH

45 E 27218

1-PLACE OF DEATH Lenkins Memorial Hospital (REGISTERED NO. 27-48

City of BALTIMORE: (No. St. Agnes Hosp, Walker Ave St., 4th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Radcliffe

(a) RESIDENCE NO. 516 Beaumont Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 7 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard H. Radcliffe

6 DATE OF BIRTH (month, day, and year): April 4 1857

7 AGE — Years: 70 Months: 6 Days: 7

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Augustus D. Hopper

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary A. E. Patterson

13 BIRTHPLACE OF MOTHER (City or town):

(State or country): Md

14 Informant: Robert L. Hopper

(Address) 4606 Maryland Ave

15 Filed ... 19... C. HARRISON JONES, M. D. Registrar

- 1927 Per ARH

very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1927, to Nov. 6, 1927, that I last saw her alive on Nov. 6, 1927, and that death occurred, on the date stated above, at 1.52 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of ? 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frances L. Radcliffe M. D.

11/6 · 1927 (Address) St Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem Date of Burial Nov 9 1927

20 UNDERTAKER: W. J. Nelson & Sons ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 27219

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2722 N Calvert ST. 12-50 WARD)

REGISTERED NO. 24-081

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Betty Croxton

(a) RESIDENCE NO. 2722 N Calvert ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE: Chester F Croxton

6 DATE OF BIRTH (month, day, and year): Mar 28 1856

7 AGE: Years 71 Months 7 Days 7 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Paris Kentucky

PARENTS

10 NAME OF FATHER: Richard S. Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Laura M Talbutt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kentucky

14 Informant: Richard S Croxton

(Address) 2722 N Calvert

15 Filed 7-1927 .19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1927, to Nov 6, 1927.

that I last saw her alive on Nov 5, 1927

and that death occurred, on the date stated above, at 6.45 a m

The CAUSE OF DEATH* was as follows: Cerebral apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Don't Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) H K Fenala, M. D.

(Address) 117 N Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Md

DATE OF BURIAL: Nov 1927

20 UNDERTAKER: H. Rudisill Son

ADDRESS: Northern

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27220

E 27220

CERTIFICATE OF DEATH.

111-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 73 N. Hilton ST.: 70 WARD)

2-FULL NAME. John H. Doare

(a) RESIDENCE. NO. 73 N. Hilton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or, ~~WIFE of~~) Ada M Doare

6 DATE OF BIRTH (month, day, and year) Feb 2 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Fireman 073

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad.

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) — Port Deposit Md

PARENTS

10 NAME OF FATHER — Thomas Doare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Pendel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Ada Doare

(Address) 73 N. Hilton St

15 Filed . 19 Registrar

11-1927 — ATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/4 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/1 . 1927, to 11/4 . 1927, that I last saw h alive on 11/4 . 1927, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J Mitchell . M. D.

11/5. 1927 (Address) 1054 Millman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	11/8 1927
20 UNDERTAKER H. C. Harrington & Son 1938	ADDRESS Lafayette Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27221

CERTIFICATE OF DEATH.

90

REGISTERED NO. E 27221

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 W 23rd St ST. 17-51 WARD)

2-FULL NAME Thomas H. Watts

(a) RESIDENCE NO. 407 W 23rd St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Isabella Watts

6 DATE OF BIRTH (month, day, and year) Feb 17, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tramp Man.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Isabella Watts
(Address) 407 W 23rd St

15 Filed 8-1927. 19. HAMILTON S. WILLIS M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1927, to Nov 7, 1927, that I last saw him alive on Nov 6, 1927, and that death occurred, on the date stated above, at 2.10 a m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. mos 10 ds

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) 1 1/2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Roscoe Rhea, M. D.

1927 (Address) 2438 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 9, 1927

20 UNDERTAKER Chenowith Son

ADDRESS 2615 Chestnut

Spec.—1-12-23—M&T—500 Blks.

Morintz

E 27222 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto General Hospital

REGISTERED NO. E 27222

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Morintz

(a) RESIDENCE NO. 134 Spring Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Morintz

6 DATE OF BIRTH (month, day, and year) Dec 30 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	38	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Otto Hillman

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Wilhelmina Eckard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Husband (Morris Morintz) (Address) 134 Spring Ave

15 [illegible] HAMPSON JONES, M. D. Registrar

NOV 8 - 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1927, to Nov 6, 1927, that I last saw her alive on Nov 6, 1927, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/28/27

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) J. C. Feldman, M. D.

, 19 (Address) 10 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Nov 8 1927

20 UNDERTAKER Ebenezer Wilson, Eastend — ADDRESS 340

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27223

CERTIFICATE OF DEATH.

90 E 27223

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 Mulberry 18-16 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Lang.

(Residence in Baltimore: No. 1035 Mulberry St ; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow.

6-DATE OF BIRTH, January 20, 1858 (Month) (Day) (Year)

7-AGE, 69 yrs. 9 mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Conrad Freyer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Freyer

(Address) 1035 Mulberry St

15- C. HAMPSON JONES, M. D.

Filed NOV 8 - 1927, 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 4, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1. 1927, to Nov 4 1927, that I saw h er alive on Nov 3 1927, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(Duration) yrs. mos. 1' ds.

(Signed) A. D. Driscoll M. D.

Nov 5, 1927 (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov 8 191..7

20-UNDERTAKER H. Strauss & Son — ADDRESS 1136 Fulton Ave

Spec.—1 12-23—M&T—500 Bks.

E 27224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 E 27224

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Poplar Grove ST., 16-66 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Chenowith

(a) RESIDENCE NO. 1125 Poplar Grove ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Chenowith

6 DATE OF BIRTH (month, day, and year) Dec 4 1849

7 AGE Years 77 Months 11 Days 2 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Woodward

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elizabeth Scally

(Address) 1125 Poplar Grove

15 Filed NOV 8 - 1927 C. HARRISON KNIGHT, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1927, to Nov 6, 1927, that I last saw her alive on Nov 6, 1927, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of omentum. 5

(duration) yrs. ? mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lee Magness, M. D.

11, 7, 1927 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 8 1927

UNDERTAKER H Brannigan Son

ADDRESS 436 Poplar Grove

Spec.—1-10-21—M&T—1500 Blks.

E 27225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 E 27225

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 Roland Ave ST., 27-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joanna Williams Snow

(a) RESIDENCE NO. 424 Roland Ave. ST. 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Snow

6 DATE OF BIRTH (month, day, and year): March 10-1864

7 AGE: Years 63 Months 7 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER: Jacob Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Middletown Delaware

12 MAIDEN NAME OF MOTHER: Mary Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dorchester Co. Maryland

14 Informant: Sarah L. Snow

(Address) 424 Roland Ave.

15 Filed NOV 8 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 6 1927

17 I HEREBY CERTIFY That I attended deceased from Sept-20 1927 to Nov. 6 1927 that I last saw her alive on Nov. 5 1927, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Diffuse Broncho-Pneumonia preceded by Acute Pulmonary Edema.

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Cardiac Arhythmia due to Sepsis-Tooth (duration) yrs. 1 mos. 16 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) M. G. Posey, M. D.

11/7 1927 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetary — DATE OF BURIAL: Nov 8 1927

UNDERTAKER: John B. Spence — ADDRESS: 1325 N Caroline St

THIS IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27226

CERTIFICATE OF DEATH.

90 1

E 27226

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2944 Hudson St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo F. Bosse

(a) RESIDENCE NO. 2906 Dillon St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie M. Bosse

6 DATE OF BIRTH (month, day, and year): June 14, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cooper at

(b) General nature of industry, business, or establishment in which employed (or employer): Sherwood Bros.

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Frank Bosse

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Adams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mamie M. Bosse (Wife)

(Address): 2906 Dillon St

15 Filed 8-1927 By C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 4. 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Coroner, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Exhaustion (duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Nov 8/27 19 (Signed) Geo Claude Wades M. D.

(Address) 143 W 13th Ray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the state yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. Date of Burial: Nov 8 1927

20 UNDERTAKER: Lilly & Geiler ADDRESS: 4038 Wolfe St.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27227

CERTIFICATE OF DEATH.

45

E 27227

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3410 Elliott ST., 26 WARD 7-37)

2-FULL NAME Katharine Wachter

(a) RESIDENCE NO. 3410 Elliott ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John Wachter

6 DATE OF BIRTH (month, day, and year) Dec 18th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ehrist Scheffleir

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katharine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Henry Wachter (Son) 3410 Elliott St.

15 Filed NOV 8 - 1927 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4th 1927

17 I HEREBY CERTIFY, That I attended deceased from 9/15/27, 19 , to 11/24 1927.

that I last saw h[illegible] alive on 11/3/27, 19

and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. C. Gurell M. D.

11/7 1927 (Address) 633-5-34

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL Nov. 8 1927

ADDRESS [illegible]

20 UNDERTAKER Lilly & Zeider

Prov. a very important fact. See instructions on back of Certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27228 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3409 Springdale Avenue ST. 15-61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME W. Frederick Groscup

(a) RESIDENCE NO. 3409 Springdale Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of Nannie E. Hardiman

6 DATE OF BIRTH (month, day, and year) May 18, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	50	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Groscup

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary L. Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs. Nannie E. Groscup

(Address) 3409 Springdale Avenue

8-8-1927 Filed , 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7, 1927.

17

I HEREBY CERTIFY, That I attended deceased from March, 1926 to Nov. 4, 1927, that I last saw him alive on Nov. 4, 1927, and that death occurred, on the date stated above, at 1.40 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Interval between onset and death (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Sclerosis of Brain Arteries

Contributed Materially, Probably one year (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Amanda H. Lovell M. D.

Nov. 7, 1927 (Address) 3705 Liberty Hgts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 11/9 1927

UNDERTAKER Henry U. Weaver & Son

ADDRESS 3705 W. Cold Spring

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27229

CERTIFICATE OF DEATH.

38 E 27229

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto City Hospital WARD)

2-FULL NAME Robert Dominguez

(a) RESIDENCE NO. Springlawn Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer O.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER McAllister Hamman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Balto City Hospt

(Address) Eastern ave & Ho

15 Filed 8-1927 16 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1927

17

I HEREBY CERTIFY, That I attended deceased from 5-28- 1927 to Nov. 4 1927

that I last saw him alive on Nov. 4 1927

and that death occurred, on the date stated above, at 8.45 m.

The CAUSE OF DEATH* was as follows:

Developed a Coccobac

Chronic Myocarditis

Lucia Colitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sign

(Signed) Hampson Jones M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	11/5 1927
20 UNDERTAKER	ADDRESS
D. J. Foley Son	1315 Eighth

Spec.–7-17-26—A Co.—200 Bks.

Back.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27230

CERTIFICATE OF DEATH

124

E 27230

1-PLACE OF DEATH University Hospital

REGISTERED NO.

City of BALTIMORE: (No. Lombard & Greene St., 14-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie E. Beck

(a) RESIDENCE NO. 1617 Eutaw Place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred W Beck

6 DATE OF BIRTH (month, day, and year) July 4 1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	56	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Theodore Carter

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary A Cobb

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Frederick Beck

(Address) 1617 Eutaw Place

NOV 8 - 1927

G. HAMPSON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11- 7 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-28, 1927, to 11-7, 1927, that I last saw h.. alive on 11-7, 1927, and that death occurred, on the date stated above, at 1 50 A. m.

The CAUSE OF DEATH* was as follows:

Empyema of the gall bladder - acute toxemia.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 10-29-27.

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings + operation

(Signed) Henry Vincent Vabra, M. D.

11. 7. 1927 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

Date of Burial Nov 10 1927

20 UNDERTAKER Joseph Appel & Son

ADDRESS Mulberry & Martin Sts

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27231

CERTIFICATE OF DEATH.

38 E 27231

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 Penna Ave. ST. 14-20 WARD)

2-FULL NAME ~~Mrs~~ Wilhelmina W. Williams

(a) RESIDENCE NO. 1823 Pa. Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur D. Williams.

6 DATE OF BIRTH (month, day, and year): 1896

7 AGE: Years 31 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fla.

PARENTS

10 NAME OF FATHER: Henry Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fla.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fla.

14 Informant (Address): Arthur D. Williams 1823 Pa Ave

15 Filed NOV 8 - 1927 H. HAMPTON MOORE, M. D., Registrar. By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/6 1927

17

I HEREBY CERTIFY, That I attended deceased from 11/2 - 1927, to 11/6 - 1927,

that I last saw her alive on 11/6 - 1927

and that death occurred, on the date stated above, at 10 20 AM

The CAUSE OF DEATH* was as follows:

Acute Gastritis

Mitral Regurgitation (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ben Rhett, M. D.

11/7, 1927 (Address) 1130 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 8 1927

20 UNDERTAKER: Grant Furniss — ADDRESS: City

Spec.—7-17-26—A Co.—200 Bks.

E 27232

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 27232

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Woodbury

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Eden ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant

(Address) Records

BALTIMORE CITY HOSPITALS

15 Filed NOV 8 - 1927 H. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/ 6/ 1927

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1926 to Nov. 6, 1927, that I last saw h alive on Nov. 6, 1927, and that death occurred, on the date stated above, at 12:05 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic acute
Emphysema
Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) C. Hubert Boyd, M. D.

, 19 (Address)

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn Cem	Nov 8 1927
20 UNDERTAKER Daniel Easton	ADDRESS 916 Ea mt

Very important. See instructions on back of certificates. Penalty attaches. Facts stated must be those of OCCUPATION IS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27233

CERTIFICATE OF DEATH.

REGISTERED NO. E 27233

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Carey St 16-23 WARD)

2-FULL NAME Addie Basken Simmons

(a) RESIDENCE No. 1016 Carey St ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Simmons

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Bird Anson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mahala Anson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Basken (Address) 1016 Carey St

15 Filed NOV 8 - 1927 C. U. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1927, to Nov 5, 1927

that I last saw h alive on Nov 5 1927

and that death occurred, on the date stated above, at 3 P m

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease
(myocarditis)

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

11-9, 1927 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 8 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Gay

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27234

CERTIFICATE OF DEATH.

161-001

E 27234

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 Bradley ST., 17-16 WARD)

2-FULL NAME Baby Normand

(a) RESIDENCE NO. 730 Bradley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7-27

7 AGE — Years — Months — Days — If LESS than 1 day, 8 hrs or m

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Amstead Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Malinda Norman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant (Address) Malinda Norman 730 Bradley

15 (Filed) NOV 8 - 1927 HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 7 1927

17 I HEREBY CERTIFY, That I attended deceased from 11-7, 1927, to 11-7, 1927, that I last saw h[illegible] alive on 11-7, 1927, and that death occurred, on the date stated above, at 9 A m

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11-7 1927 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 8 1927

UNDERTAKER: Druid Funeral — ADDRESS: 816 Ost ave

FOR IS VERY IMPORTANT. SEE INSTRUCTIONS

Spec.—1-10-21—M&T—1500 Bks.

E 27235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27235

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Kentucky av. ST., 9-45 WARD) 40

2-FULL NAME John W. Faver

(a) RESIDENCE NO. 2116 Kentucky av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Sophia Faver
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Otto Faver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Frisch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sophia Faver
(Address) 2116 Kentucky av.

15 Filed NOV 8 - 1927. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6. 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 6. 1925. to Nov. 5th 1927.

that I last saw him alive on Nov. 5th 1927.

and that death occurred, on the date stated above, at 11 20 A. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular heart disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert F. Green, M. D.

(Address) 120 Eighth St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cemetery	Nov 9 1927
20 UNDERTAKER	ADDRESS 203
Henry Lutz	N. Broadway

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

L 27236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27236

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 10-14 WARD)

2-FULL NAME Hammond Drumgold

(a) RESIDENCE NO. 1138 E. Monument St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10-17-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER — ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosa Drumgold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Relative
(Address)

15 Filed NOV 8 - 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1927, to Nov. 5, 1927, that I last saw h alive on Nov. 5, 1927, and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) C. C. Graham, M. D.

(Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laura Cem.	Nov. 8 1927
20 UNDERTAKER Mrs J. G. Locke	ADDRESS 302 Jefferson St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27237

91-002

E 27237

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2799 Leadenhall St. Ward 51)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bradley Stone

(a) RESIDENCE NO. 2799 Leadenhall St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 9/1841

7 AGE: Years 86 | Months 8 | Days 25 | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md

(State or country)

PARENTS

10 NAME OF FATHER John Stone

11 BIRTHPLACE OF FATHER (city or town) Frederick

(State or country)

12 MAIDEN NAME OF MOTHER Mary Rick

13 BIRTHPLACE OF MOTHER (city or town) Frederick

(State or country)

14 Informant John Stone

(Address) 2799 Leadenhall

Filed NOV 8 - 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) Nov 5th 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 16 1927, to Nov 5 1927, that I last saw h[illegible] alive on Nov 5 1927 and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Uraemia following Long duration Chronic Gastritis.

(duration) .....yrs. 3 mos. .....ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) .....yrs. .....mos. 2 ds.

Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) R. B. Normand, M. D.

N.Y. 1927 (Address) 354 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's H. Date of Burial Nov 8 1927

20 UNDERTAKER E Hasson ADDRESS 841 W 31st

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 27238 REGISTERED NO.

E 1-27238 DEATH

City of BALTIMORE: (No. St. Agnes Hospital 170-64 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Spath.

(a) RESIDENCE NO. 2517 W. Fayette St. Balt Md Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? 17 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): January 19 1863

7 AGE: Years 65 Months 7 Days 19 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Cathedral Cemetery

9 BIRTHPLACE (city or town):

(State or country): Germany.

PARENTS

10 NAME OF FATHER: Stoffel Knorr

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Stoffel Knorr

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Frank F. Spath

(Address) 2017 Fontaine St

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

NOV 8 - 1927

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

November 6 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-29, 1927, to 11-6, 1927, that I last saw h— alive on 11-6, 1927, and that death occurred, on the date stated above, at 11 E p.m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Cerebral Hemorrhage

Hemiplegia - Left side.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) O. J. Knapp, M. D.

11-6, 1927. (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL: St Pl Cem Date of Burial NOV 9 - 1927 19

20 UNDERTAKER: Geo W Little ADDRESS

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27239 49 ✓ E 27239

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 414 Lake Ave. St., 27-53 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie A. Bushnell

(a) RESIDENCE NO. 414 Lake Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? Bushnell

6 DATE OF BIRTH (month, day, and year) July 16, 1861

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ballston Spa

(State or country) New York

PARENTS

10 NAME OF FATHER Francis Bassett

11 BIRTHPLACE OF FATHER (City or town) Ashefield

(State or country) Mass.

12 MAIDEN NAME OF MOTHER Cortelia Swift

13 BIRTHPLACE OF MOTHER (city or town) Ashefield

(State or country) Mass.

14 Informant H. E. Cook

(Address) 414 Lake Ave.

15 Filed NOV 8 - 1927 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 November 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to Nov 7, 1927, that I last saw her alive on Nov 6, 1927, and that death occurred, on the date stated above, at 4 P. a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S. Fenby, M. D.

11/8, 19 27 (Address) 1 E. Preston Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reeves Remains to Kensico Cemetery, N. Y. Date of Burial 11/8/27 19

20 UNDERTAKER H. E. Cook ADDRESS 1003 W. Baltimore St.

Fill in blanks in plain terms, so that it may be very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27240

CERTIFICATE OF DEATH

128 E 27240

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 824 Whatcoat St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Boyer

(a) RESIDENCE NO. 824 Whatcoat St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Boyer

6 DATE OF BIRTH (month, day, and year) 8-17-1876

7 AGE	Years	Months	Days
	51	2	19

IF LESS than 1 day ..... hrs. or ..... min.. 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) worked at poultry place

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. Md

(State or country)

PARENTS

10 NAME OF FATHER Jessie Boyer

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Rachel Butler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Calvert Co. Md

14 Informant Elizabeth Boyer (wife)

(Address) 824 Whatcoat St

15 Filed NOV 8 - 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5- 1927

17 I HEREBY CERTIFY, That I attended deceased from 11-2- 1927, to 11-5- 1927,

that I last saw him alive on 11-5 1927,

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

uremia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) nephritis and alcoholism

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Frank A Saunders M. D.

11-5- 1927 (Address) 1029 N Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — Date of Burial Nov. 8 1927

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Riesterstown St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27241

CERTIFICATE OF DEATH.

74-001

74 E 27241

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 Mc Culloh ST. 14-20 WARD)

2-FULL NAME Frances Fields

(a) RESIDENCE NO. 1820 McCulloh ST. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Fields

6 DATE OF BIRTH (month, day, and year) May 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) ✓

12 MAIDEN NAME OF MOTHER ✓

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ✓

14 Informant William Howard (Address) 1820 McCulloh

15 Filed NOV 8 - 1927 C. HAMPSON JONES, M. D. Registrar per RAC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/6 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/24, 1927, to 11/6, 1927, that I last saw h alive on 11/5, 1927, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hem. Hemiplegia (duration) 1 yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Old age. (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lee Hill, M. D.

11/7, 1927 (Address) 724 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL 11-9 1927

20 UNDERTAKER George T. A. Gibson — ADDRESS 1735 Druid Hill

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27242

CERTIFICATE OF DEATH.

74-09 E 27242

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 725 S Lakewood St. 1-B Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie A Gray

(a) RESIDENCE NO. 725 S Lakewood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Gray.

6 DATE OF BIRTH (month, day, and year): March 5, 1865

7 AGE: Years 62 Months 7 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Peter Close

11 BIRTHPLACE OF FATHER (city or town)

(State or country) France

12 MAIDEN NAME OF MOTHER Mary E Kuster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant James Gray

(Address) 725 S. Lakewood ave

Filed NOV 8 - 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry and Ext. find that said deceased came to death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

Ext. Duration) 4 yrs. 8 mos. 0 ds.

CONTRIBUTORY (Secondary) Chronic

(Duration) yrs. mos. 1 ds.

(Signed) G C Yates M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Century — Date of Burial: Nov 8, 1927

20 UNDERTAKER: John F Moran — ADDRESS: 3000 E. Balto.

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 27243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 111-001 E 27243

1-PLACE OF DEATH University Hospital REGISTERED NO.

City of BALTIMORE: (No. Lombard & Greene St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence H Kopp

(a) RESIDENCE NO. 615 Old Home Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Kopp

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Henry Kopp

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Georgia Seaton

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Hospital Record

(Address)

Filed 8-1927 C. HAMPSON JONES, M.D., Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/3, 1927, to 11/7, 1927,

that I last saw h.l.m. alive on 11/7, 1927,

and that death occurred, on the date stated above, at 7 00 P. m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of 11/5/27

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. E. Rafsnyder, M. D.

11/7, 1927 (Address) Lombard & Green, Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem Date of Burial Nov 10 1927

20 UNDERTAKER John Ulrich ADDRESS 200 N Calvert

11011 23

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27244

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27244

CERTIFICATE OF DEATH.

REGISTERED NO. 16-2 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 S Clinton ST. 16-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Walters

(a) RESIDENCE NO. 1222 S Clinton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ehart Walters

6 DATE OF BIRTH (month, day, and year): Don't Know

7 AGE — Years: 68 — Months: — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Nicholas Ditzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Albany

14 Informant: Henry Walters

(Address): 222 S Clinton

Filed 11-8-1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1927, to Nov 7, 1927, that I last saw h ev alive on Nov 6, 1927 and that death occurred, on the date stated above, at 5 45 am

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace G Tilson, M. D.

11 8, 1927 (Address) 315 S. Highlandtown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Nov 9 1927

20 UNDERTAKER: Sondheim

ADDRESS: 200 Aisquith

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 27245

CERTIFICATE OF DEATH

129 E 27245

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1818 Barclay St. 1219 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary E. Cole

(a) RESIDENCE NO. 1818 Barclay St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7/12 yrs. / mos. / ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed ~~or divorced~~ ~~HUSBAND of~~ ~~(or) WIFE of~~: Col. Henry A. Cole.

6 DATE OF BIRTH (month, day, and year): about ? ? ?

7 AGE: Years 83 / Months — / Days — / IF LESS than 1 day ___ hrs. or ___ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: ——— Smith

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Dorothy H Wolff

(Address) 1531 Linden Ave

15 Filed 8-1927 C. HAMPSON JONES, M. D. Registrar

Per RPB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1927

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1926, to Nov 7, 1927, that I last saw her alive on Nov. 5, 1927, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows: See note on back

Chronic Nephritis

(duration) 4 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary): Valvular Heart disease (Mitral valve)

(duration) ✓ yrs. 6 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No —

What test confirmed diagnosis? Clinical methods

(Signed) George E. Shannon, M. D.

11/7, 1927 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Frederick Maryland	11/10 1927
20 UNDERTAKER	ADDRESS
Ulman Cook	502 E Baltimore St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27246

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 11 East Gibbon Ave (St.) Homeopathic (Ward)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Foreman

(a) RESIDENCE No. 11 East Gibbons Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susie Foreman

6 DATE OF BIRTH (month, day, and year): Aug 27 1847

7 AGE — Years: 80 — Months: 2 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman 032

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad 514

(c) Name of employer: Salvage Corps

9 BIRTHPLACE (city or town) (State or country): Galt Md

PARENTS

10 NAME OF FATHER: John Foreman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Galt Md

12 MAIDEN NAME OF MOTHER: Mary Josey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Susie G. Foreman

(Address): 11 East Gibbons Ave

15 Filed 8-1927, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6 1927

17 I HEREBY CERTIFY, That I attended deceased from May 15th, 1927, to Nov 6th, 1927, that I last saw him alive on Nov 6th, 1927, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Uremia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examinations

(Signed) H B Lutherhaus, M. D.

11/7, 1927 (Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: 11/9 1927

20 UNDERTAKER: H. C. Cook — ADDRESS: 502 E North Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27247

E 27247

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2030 N. Washington ST., 17 WARD)

2-FULL NAME Jennie E Gleseme

(a) RESIDENCE NO. 2030 N. Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Robert Gleseme

6 DATE OF BIRTH (month, day, and year): May 22. 1856

7 AGE: Years 70 | Months 5 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Glenrock Pa

PARENTS

10 NAME OF FATHER: Charles Gantz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Catherine Gorman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Mrs Naomi Smallwood 2030 N Washington St

15 Filed 1927 C. HAMPSON JONES, M. D., Registrar. By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1927

17 I HEREBY CERTIFY, That I attended deceased from September 10. 1927. to November 7. 1927; that I last saw h[er] alive on November 6 1927, and that death occurred, on the date stated above, at 12:10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver and Intestines

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Cachexia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Riesenberg, M. D.

11/7 1927 (Address) 2025 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Drummond

DATE OF BURIAL: 11/9 1927

20 UNDERTAKER: W. M. Cook

ADDRESS: 502 E Balto St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27248

CERTIFICATE OF DEATH

90 E 27248

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3929 Falls Road St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Lockner Sr.

(a) RESIDENCE NO. 3929 Falls Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 11/1852

7 AGE — Years: 75 Months: 7 Days: 26

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town): Manchester

(State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: Jacob Lockner

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Carroll Co. Md.

12 MAIDEN NAME OF MOTHER: Catherine Leigh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Carroll Co. Md.

14 Informant: Aquilla Lockner

(Address): 3929 Falls Road

15 Filed ..... 19 ..... Registrar

1927 C. HARPER JONES, M.D.

NRP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1927

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1927, to Nov. 7, 1927, that I last saw him alive on Nov 6, 1927, and that death occurred, on the date stated above, at 2.10 A m.

The CAUSE OF DEATH* was as follows:

Cancer in Dilatation

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): Arteria Sclerosis Myocarditis

(duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Lamb, M. D.

(Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — Date of Burial: 11/9 1927

20 UNDERTAKER: J. Wallis Dove — ADDRESS: 3307 Fairmount Ave

very important. See instructions on back of certificates.

Spec.—1-12-25—M&T—500 Blks.

E 27249

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27249

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 N. Spring ST., 9-17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Wm. Jenkins

(a) RESIDENCE NO. 1615 N. Spring ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Katherine Jenkins

6 DATE OF BIRTH (month, day, and year) Mch. 30. 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	36	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 004

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md

PARENTS

10 NAME OF FATHER J. W. Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Sallie Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md.

14 Informant Katherine Jacobs
(Address) 1615 N Spring St

15 [illegible]-1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 7 1927

17 I HEREBY CERTIFY, That I attended deceased from November 7, 1927, to November 7, 1927, that I last saw him alive on November 7, 1927, and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Cardiac failure - Lobar Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) William F. Ehwart, M. D.

11/7, 1927 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rose Hill Cemetery Hagerstown, Md.

DATE OF BURIAL Nov. 9 1927

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27250 E 27250

CERTIFICATE OF DEATH.

179

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 218 N. Carlton St. 18-16 Ward)

2-FULL NAME George Cornish

(a) RESIDENCE NO. 218 N. Carlton St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 70 — Months: — Days: — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Canada.

PARENTS

10 NAME OF FATHER: Aron Cornish

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): "

14 Informant: Mary Kane (Sister)

(Address): 218 N. Carlton St.

15 Filed 8-1927 C. HAMPSON JONES, M. D. Registrar

Per RCB

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31st 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained thereat and (Inquest, Autopsy or Inquiry) find that said deceased came to death on the day stated above.

(Autopsy or Inquiry.)

The CAUSE OF DEATH* was as follows: Entire body burned — dead when found — Do not know how it happened

Thos. B. Gorton M. D.

(Signed) (Coroner)

Oct 31 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

(Duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(Duration) ____ yrs. ____ mos. ____ ds.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the state ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

Very Important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 27251

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27251

CERTIFICATE OF DEATH

111-001

1-PLACE OF DEATH

REGISTERED NO. 16-23

City of BALTIMORE: (No. 744 N. Carrollton Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cook H. F. Hahn

(a) RESIDENCE NO. 744 N. Carrollton Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clara M. Cook

6 DATE OF BIRTH (month, day, and year) May 25 1860

7 AGE	Years	Months	Days
	67	5	12

IF LESS than 1 day.....hrs. or.....min.. 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Hahn

11 BIRTHPLACE OF FATHER (City or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Kuhl

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Clara M. Hahn
(Address) 744 N. Carrollton Ave.

8 Jan 1927 C. HAMPSON JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6, 1927

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1926, to Nov 6, 1927,
that I last saw him alive on Nov. 5, 1927,
and that death occurred, on the date stated above, at 2:15 A. m.
The CAUSE OF DEATH* was as follows:

Gastric Hemmorhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY Gastric ulcer
(Secondary)
almt (duration) 5 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) Theodore H. Morrison M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loud Ridge Cem	Nov 19 27
20 UNDERTAKER John C. Mitchell & Sons	ADDRESS 1900 Eutaw St.

very important. See instructions on back of certificates.

E 27252

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27252

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. St Elizabeths Home Chestnut & Glenwood Ave St.; 9-47 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Asbury Snowden Butler

(Residence in Baltimore: No. New Dairy Md. St.: 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: negro

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March 6, 1925 (Month) (Day) (Year)

7 AGE: 2 yrs. 8 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Elgie Butler

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Minnie Snowden

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elgie Butler
(Address) Woodbine

15 [illegible] C. HAMPSON JONES, M. D.
8-1927 By [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November 7, 1927 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September, 1927, to November 7 1927, that I saw him alive on November 7, 1927, and that death occurred, on the date stated above, at 11:50 P.m.
The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) yrs. 2 mos. ds

Contributory (SECONDARY) Bronchopneumonia

(Duration) yrs. mos. 21 ds.

(Signed) Frank J. Ayd M. D.
Nov 8, 1927 (Address) 2025 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Dairy Cemetery Howard Co.,
DATE OF BURIAL: Nov 9, 1927

20 UNDERTAKER: H. M. Snyder
ADDRESS: Mt Airy

THE CAUSE OF DEATH is to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27253

CERTIFICATE OF DEATH.

129 E 27253

1-PLACE OF DEATH

City of BALTIMORE: (No. 706 Mosher St. 17-23 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace H. Tingle

(a) RESIDENCE NO. 706 Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Ellen Tingle

6 DATE OF BIRTH (month, day, and year) 10-7-1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Drayman

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Horace Tingle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Rowley

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Ellen Tingle (Wife)

(Address) 706 Mosher St

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 11/7/27

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1927, to Nov. 7, 1927, that I last saw him alive on Oct. 7, 1927, and that death occurred, on the date stated above, at 10:23 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis

(Duration) yrs. 6 mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins M. D.

, 19 (Address) 1019 Lind Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Snow Hill Md. Nov. 9 19 27

20 UNDERTAKER J. M. Thomas ADDRESS 1234 Ething St.

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27254

CERTIFICATE OF DEATH.

100 E 27254

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 507 S. Madeira St. 1-3 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Frank Smiglewski

(a) RESIDENCE NO. 507 S. Madeira St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 21 1906

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	21 / 20	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Candy Maker

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jacub Smiglewski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Cegielska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Josephine Smiglewski

(Address) 507 S Madeira St.

8-1927 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1927, to Nov 6, 1927, that I last saw him alive on November 5, 1927, that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Finger, M. D.

, 19 (Address) 1627 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St. Stanislaus Nov 10 1927

20 UNDERTAKER — ADDRESS

John A. Weber 1803 Eastern Ave

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27255

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 Fleet St. ST. 2-4 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emilia Przybylska

(a) RESIDENCE NO. 1739 Fleet St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Ida Jones Daughter
(Address) 584 S. Castle St.

15 Filed NOV 8 1927, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1927, to Nov 7, 1927, that I last saw her alive on Nov 6, 1927, and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Coma (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. A. Sneer, M. D.

11/7/19 27 (Address) 408 Pat Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 11-10 19 27

20 UNDERTAKER John M. Weber ADDRESS 843 Hanover

Spec.—1-12-23—M&T—500 Bks.

E 27256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-081

E 27256

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 N Milton St. ST. 6-10 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Poffel

(a) RESIDENCE NO. 133 N Milton St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 29 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Real Eastate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Michael Poffel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Rutkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Poffel
(Address) 133 N. Milton St.

Filed 8-1927, 19 By RKH Registrar

C. HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/5, 1927, to 11/7, 1927, that I last saw h[illegible] alive on 11/7, 1927, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Oral [illegible] infection, [illegible] edema of glottis & asphyxia

(duration) ..... yrs. ..... mos 3 d ds.

CONTRIBUTORY (Secondary) Bronchopneumonia & pleurisy fibrinous

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Signs & symptoms

(Signed) Harry A Rutkow, M. D.

, 19 (Address) 1628 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	[illegible] 19
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

Spec.—1-10-21—M&T—1500 Bks.

E 27257

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 27257

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 519 N. Hamburg ST., 21-31 WARD

2-FULL NAME Eliza Gerhold

(a) RESIDENCE NO. 519 N. Hamburg ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Gerhold

6 DATE OF BIRTH (month, day, and year): Feb 10, 1847

7 AGE — Years: 80 — Months: 8 — Days: 28 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Fiebel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary E. Rochnlein
(Address): 519 N. Hamburg St.

15 - 1927 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1927, to Nov. 7, 1927, that I last saw her alive on Nov. 6, 1927, and that death occurred, on the date stated above, at 2.05 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia (Chronic)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Chronic Parenchymatous Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Hands Chenoweth M.D.

Nov 9 1927 (Address) 933 Reservoir

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: Nov 9. 1927

20 UNDERTAKER: Mrs. Mrs. John N. Teufel & Son — ADDRESS: 801 W. Fayette St.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 27258

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27258

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1155 Carroll ST. 21-29 WARD)

2-FULL NAME David Jr Morgan

(a) RESIDENCE NO. 1155 Carroll ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Morgan

6 DATE OF BIRTH (month, day, and year) June 19. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87.	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George W. Sears. (Address) 4. Brooklea Peace

15 8 - 1927 C. HAMPSON JONES, M. D. Registrar Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1927

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1927, to Nov 8 1927

that I last saw h alive on Nov 8 1927

and that death occurred, on the date stated above, at 4.30 a/m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemor

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Sears, M. D.

, 19 (Address) 1927 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL Nov 10 1927

20 UNDERTAKER Mrs Mrs J. W. Pendleton ADDRESS 801 W Lafayette

TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27259

CERTIFICATE OF DEATH

× 16-98 E 27259

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Elizabeth Mitchell

(a) RESIDENCE NO. Ellicott City Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
March 12, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
		7	24 26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Ellicott City
(State or country) Howard Co Md

PARENTS

10 NAME OF FATHER Wade H Mitchell
11 BIRTHPLACE OF FATHER (City or town)
(State or country) Md
12 MAIDEN NAME OF MOTHER Hazel Porter
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Wade H Mitchell
(Address) Ellicott City Md

15 Filed 19A [illegible] C. HARRISON JONES, M. D. Registrar
[illegible] - 1927 RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
November 8-1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1927, to Nov 8, 1927, that I last saw her alive on Nov 8, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Acute Gastro-enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Emaciation & Dehydration

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Ellicott City Md
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) E E Linsley, M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Ellicott City	Nov. 9 1927
20 UNDERTAKER	**ADDRESS**
Scott M. Starr	Ellicott City

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27260

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27260

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2027 (St.) Pulaski (Ward) 15-59

REGISTERED No. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph John Carter

(a) RESIDENCE No. 2027 Pulaski ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Alvenda Carter

6 DATE OF BIRTH (month, day, and year) Sept. 10. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	80	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Jesse Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Sarah Whitaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hubert Carter

(Address) 201 E. Mt. Royal Ave.

15 Filed 8-1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 28, 1927, to Nov 7, 1927.

that I last saw him alive on Nov 7, 1927

and that death occurred, on the date stated above, at 4:30 A m

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Oliver Murray, M. D.

Nov 8, 1927 (Address) 1517 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Thomas Cem Hanson Forest

DATE OF BURIAL Nov. 10 1927

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1424 W. North Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27261

CERTIFICATE OF DEATH.

31 ✓

REGISTERED NO. E 27261

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 411 N Pine St. 17-25 Ward)

2-FULL NAME Fro A. Summerfield

(a) RESIDENCE NO. 411 N Pine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: single

6 DATE OF BIRTH (month, day, and year): 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: George Summerfield

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Mary M Thomas

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Mrs Summerfield

(Address): 411 N Pine

6 AON

C. 19 HARRY BOYD JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 5 1927 19

17

I HEREBY CERTIFY, That I attended deceased from Sept 16 1927 to Nov 5 1927,

that I last saw h..... alive on Nov 4 1927,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National City — Date of Burial: Nov 9 1927

20 UNDERTAKER: Leard & Whalen — ADDRESS: 308 Myrtle ave

Be very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27262

CERTIFICATE OF DEATH.

X 71-001 E 27262

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO._____

City of BALTIMORE: (No. Monument St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice D Abramson

(a) RESIDENCE NO. Richmond Va St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7th 1926

7 AGE — Years: 1 — Months: 2 — Days: 2 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Va

PARENTS

10 NAME OF FATHER Harry Abramson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Bloom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Buffalo N Y

14 Informant Harry Abramson (Address) Richmond Va

15 Filed 19 HAMPSON JONES, M. D. Registrar

NOV 9 1927.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1927, to Nov 9, 1927, that I last saw h[illegible] alive on 11-9, 1927, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Pneumococcic Meningitis

(duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? Unona

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Milton Sherry, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va — Date of Burial 11/9 1927

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27263

177 E 27263

CERTIFICATE OF DEATH.

REGISTERED NO.

E 27263
1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Hosp St., 14 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Melnicore

(a) RESIDENCE NO. 1538 Penna ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 19 1899

7 AGE: Years 28 Months 2 Days 12

If LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: accountant

(b) General nature of industry, business, or establishment in which employed (or employer): Clothing factory

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Melnicore

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachel Grossman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Mrs Grossman

(Address): 1538 Penna ave

15 Filed 19

Registrar

NOV 9 - 1927 HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8- 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, Inquiry ...fied that said deceased came to h... death (opsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows: Acc D'sease due to overdose of Allonal

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Ec Laxative

(Duration) ... yrs. ... mos. 2 hr

(Signed) G Glades M. D.

(Coroner)

Nov 8/27 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the state ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehrens Woods Rd Date of Burial 11/9 1927

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balto St

very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27264

CERTIFICATE OF DEATH

90

E 27264

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. University Hospital St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Johnson

(a) RESIDENCE NO. 1129 E Sharp St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Johnson.

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE: Years 44 Months Days

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Annie Mottus

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Evans

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Virginia

14 Informant George Johnson

(Address) 1129 E Sharp St.

15 Filed NOV 9 - 1927

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 27

Nov. 5

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 19 27, to Nov. 5, 19 27

that I last saw h alive on Nov. 5, 19 27

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic cardiac vascular disease with mitral stenosis & insufficiency

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Chronic) (duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. J. Digby, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Date of Burial Nov 9 19 27

20 UNDERTAKER Emmert & Hemsley

ADDRESS 75 Belnord

Very important. See instructions on back of certificates. Every statement must be properly classified. Exact statement of OCCUPATION is

Spec.—8-24-14—M. & T.—2000 Bks.

E 27265

HEALTH DEPARTMENT—CITY OF BALTIMORE

34 E 27265

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Children Hospital School St. 11-2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sylvia Eveline Bodley.

(Residence in Baltimore: No. 1106 Madison Ave. St.; 3 yrs., 2 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Aug. 20, 1924 (Month) (Day) (Year)

7-AGE, 3 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none.
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Fords Farm. Baltimore Md.

PARENTS.

10-NAME OF FATHER, Thomas Brown.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Helen Bodley

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laurence B. Cheeseman

(Address) Children Hospital School

15- Nov 9 1927 C. HAMPSON JONES, M. D.

Filed ....., 191... Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 8, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1927, to Nov. 8 1927, that I saw her alive on Nov. 8 1927, and that death occurred, on the date stated above, at 2.35 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Spine

(Duration) 1 yrs. mos. ds.

(Signed) Laurence B. Cheeseman M. D.

Nov. 8, 191... (Address) Children Hosp. School

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 3 mos. 0 ds. In the State 3 yrs. 2 mos. 17 ds.

Where was disease contracted, if not at place of death? at place of death

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, 11.9, 1927

20-UNDERTAKER Paul T. Bowley — ADDRESS 578 N Bidde

Spec.—1-12-23—M&T—500 Bks.

E 27266

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 27266

1-PLACE OF DEATH Hebrew Home for Aged REGISTERED NO.

CITY OF BALTIMORE: (No.) 2100 E. Balto St. (Ward) 6-10

(If death occurred in a hospital or institution, give its NAME instead of street and number:)

2-FULL NAME Yehuda Rose

(a) RESIDENCE No. 2330 E. Fairmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Liba Rose

6 DATE OF BIRTH (month, day, and year): Autumn.

7 AGE — Years: 85 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: old age

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Yehuda Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Pinkowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Home

(Address)

Nov 9 1927 — H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8 19 27

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1927, to Nov 7, 1927, that I last saw him alive on Nov 7, 1927, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial weakening

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Cemetery — DATE OF BURIAL: Nov 9 1927

20 UNDERTAKER: Jack Levin — ADDRESS: 1419 Eutaw

Spec.—1-12-23—M&T—500 Bks.

E 27267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 27267

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Ogden Ave, Hamilton ST. 27-44 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F Sondheim

(a) RESIDENCE NO. 12 Ogden Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jessie Sondheim

6 DATE OF BIRTH (month, day, and year): Aug 7, 1858

7 AGE — Years: 49 | Months: 3 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 014

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Geo. F. Sondheim

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Mary Ann Caulk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Geo. F. Sondheim
(Address): 112 E. Hamilton Ave

15 Filed NOV 9 - 1927 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1 , 1927, to Nov, 7 , 1927, that I last saw him alive on Nov, 7, 1927, and that death occurred, on the date stated above, at 4.18 p. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. ? mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lee Hagness, M. D.

11/8, 1927 (Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: Nov 9 1927

20 UNDERTAKER: W. Cook

ADDRESS: 502 E Monument

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27268

CERTIFICATE OF DEATH.

49 E 27268

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Warwick Ave. St. 15-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Schochett

(a) RESIDENCE NO. 1630 Warwick ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~5~~ 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 17-1922

7 AGE: Years 5 Months 2 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Mary's County Maryland

PARENTS

10 NAME OF FATHER Benj. Schochett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Besse Base

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Benj. Schochett 1630 Warwick ave

15 Filed NOV 9 - 1927 19 C. HAMPSON JONES, M. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1927, to Nov 8th, 1927, that I last saw him alive on Nov 8th, 1927, and that death occurred, on the date stated above, at 4.20 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Edema of Larynx.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Convulsions Epileptiform Acidosis Malnutrition

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of 6/27/27

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) A. J. Ficcio, M. D.

11/9, 1927 (Address) 20 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL 11/9 19 27

20 UNDERTAKER: D. Jack Lewis

ADDRESS 1439 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

E 27269

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27269

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2330 E North ave ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Edlinger

(a) RESIDENCE NO. 2330 E North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Albert Edlinger

6 DATE OF BIRTH (month, day, and year) Sept 19th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andreas Hermand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frederica Furman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Albert Edlinger

(Address) 2330 E North ave

Filed NOV 9 - 1927 C. HAMPSON JONES, M.D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1919, to Nov 7th, 1927, that I last saw her alive on Nov 7th, 1927, and that death occurred, on the date stated above, at 1115 P. m.

The CAUSE OF DEATH was as follows:

Diabetis Endocarditis

Mitral Insufficiency

(duration) 8 yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus Pneumonia

(duration) 8 yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Joseph B. Lambert, M. D.

, 19 (Address) 719 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Nov 10th 1927

ADDRESS

20 UNDERTAKER George Schilling & Sons Nicholson

IMPORTANT. See instructions on back of certificates.

Spec.—12-8-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27270

161-001

CERTIFICATE OF DEATH.

E 27270

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Friedlander

(a) RESIDENCE NO. 1027 E. Baltimore St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White (Jewish)	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-8-27

7 AGE	Years	Months	Days	IF LESS than 1 day 17 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...0...

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Aaron Friedlander

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Miriam Sevel

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Russia

14 Informant Aaron Friedlander

(Address) 1027 E. Balto. St

15 Filed NOV 9 - 1927 C. HAMPSON JONES, M. D. Registrar

Per CRC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 | 9 | 1927

17 I HEREBY CERTIFY, That I attended deceased from 11-8 1927, to 11-9, 1927,

that I last saw h.. alive on 11-9, 1927,

and that death occurred, on the date stated above, at 7:55 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Schuman, M. D.

11-9, 1927 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fitzner Herring Bur. Date of Burial 11/9 1927

20 UNDERTAKER Fitzner Herring ADDRESS 1127 E Balto st

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27271

CERTIFICATE OF DEATH.

90 v

E 27271

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1110 E. Lombard St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Meyer Cohen

(a) RESIDENCE NO. 1110 E. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? 34 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 56 Months — Days — IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER: Henry Cohen

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Hilda

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant: Henry Cohen

(Address) 1110 E Lombard St

NOV 9 - 1927

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 7 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry find that said deceased came to his death (autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) Ex Lausted yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) (Antecedent) yrs. mos. 1 ds.

Nov 7/27 (Signed) G E Ladd M. D.

(Coroner)

19 (Address) 143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the state yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Rest Date of Burial Nov 9, 1927

20 UNDERTAKER: M. E. Thomas Bro Butler ADDRESS 1112 E

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27272

CERTIFICATE OF DEATH.

1927 E 27272

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie Turner

(a) RESIDENCE NO. 912 Shield Place Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race: Female colored

5 Single, Married, Widowed, or Divorced, (write the word): single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 9 1893

7 AGE: Years 34 Months 7 Days 17 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waitress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: General

9 BIRTHPLACE (city or town)

(State or country): Md.

PARENTS

10 NAME OF FATHER James Turner

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER Mary Randall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Mamie Anderson

(Address) 1307 Argyle ave.

15 Filed NOV 9 - 1927 19 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun-shot wound in head.

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBITORY (Secondary) Homicide

(duration) ..... yrs. ..... mos. ..... ds.

Signed) J. T. Tennessan (Coroner) M. D.

Nov. 5 19 27 (Address) 1572 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brew Hill Annapolis Md.

Date of Burial: 11-10 1927

20 UNDERTAKER: Joseph A. Lively

ADDRESS 409 W. Mount street.

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27273

CERTIFICATE OF DEATH.

1 81 E 27273

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. #604 N. East Ave. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer L. Rehmert

(a) RESIDENCE NO. #604 N. East Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24th. 1909

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	18	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Poly. Student

(b) General nature of indpstry, business, or establishment in which employed (or employer) School

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto.

PARENTS

10 NAME OF FATHER Frederick D. Rehmert

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Marybell Glasser

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Frederick D. Rehmert

(Address) 604 N. East ave

15 Filed NOV 9 - 1927 By C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5th 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an_____ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said_____ (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Gas (illuminating)

Asphixiation

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Fisher M. D.

(Coroner)

19 (Address) 500 E. North Ave

11/6/27

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Date of Burial Nov 9 1927

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 27274

CERTIFICATE OF DEATH

38 E 27274

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1008 N. Calvert St St. 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Winslow Williams

(a) RESIDENCE NO. 1005 N. Calvert St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 6th 1864

7 AGE 63 Years / Months / Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer -

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Own firm - Williams, Williams

9 BIRTHPLACE (city or town) Buffalo

(State or country) New York

PARENTS

10 NAME OF FATHER John Butler Williams

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Charleston, South Carolina

12 MAIDEN NAME OF MOTHER Caroline S. Winslow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Cleveland, Ohio

14 Informant David C. Stanford

(Address) 1005 N. Calvert St

15 Filed NOV 9 - 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

11-7-27

17 I HEREBY CERTIFY, That I attended deceased from 10-23, 1927, to 11-7, 1927, that I last saw him alive on 11-7, 1927, and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

CEREBRO-SPINAL [illegible]

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 129 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. — Date of Burial Nov 9th 19 27

20 UNDERTAKER: Henry H. Jenkins Sons — ADDRESS McCulloh, Baltimore

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27275

CERTIFICATE OF DEATH.

E 27275

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. WARD)

2-FULL NAME Wilmer R. Holland

(a) RESIDENCE NO. Elkton, Md ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 7-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	51	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Common Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jos. Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Clara Gordon

(Address) Elkton

15 NOV 9 - 1927 Filed C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1927, to Nov. 9, 1927,

that I last saw h[illegible] alive on Nov. 8 1927

and that death occurred, on the date stated above, at 4 00 Pm

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. unknown mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) John O. Lamb, M. D.

(Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton. Md DATE OF BURIAL Nov 9 1927

20 UNDERTAKER W. S. Coppin ADDRESS Elkton, Md

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27276

24 0 25 E 27276

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 4-20 WARD)

REGISTERED NO. 154

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ROSIE GIBSON

(a) RESIDENCE No. 1407 ETTING Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	Colored	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-9-27

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or min.
	3 Weeks	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER HOWARD GIBSON

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER MISSOURI-SAVAGE

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Ricardo JOHNS HOPKINS HOSPITAL
(Address)

15 NOV 9 - 1927 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-7 1927

17

I HEREBY CERTIFY, That I attended deceased from October 10, 1927, to Nov-7, 1927, that I last saw her alive on November 7, 1927, and that death occurred, on the date stated above, at 12 mid. m.

The CAUSE OF DEATH* was as follows:

?

Dermatitis Exfoliativa 2 weeks
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? \ Date of \

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. C. Gradon, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Nov 9 1927

UNDERTAKER John W. Soader — ADDRESS 1027 Hillsdale

TION is very important See instructions on back of certificates.

Spec.--7-17-26--A Co.--200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27277.

CERTIFICATE OF DEATH

29 ✓ E 27277

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1360 Andre St. 24-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRANCES MAJEWSKI,

(a) RESIDENCE NO. 1360 Andre St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Michael Majewski,

6 DATE OF BIRTH (month, day, and year)
Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	81	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland,

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mrs. Koreman

(Address) 1360 Andre St

NOV 9 - 1927

C. HAMPSON JONES M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Nov. 7 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 19 27, to Nov. 7, 19 27,

that I last saw h[illegible] alive on Nov. 6, 19 27,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic Valvular Heart Disease

Aortic Sclerosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurg. Decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hist

(Signed) Troy F. Stevens, M. D.

11 7, 19 27 (Address) 2878 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, Date of Burial Nov. 11 1927

20 UNDERTAKER M. F. Sadowski, ADDRESS 705 Lum

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27278

CERTIFICATE OF DEATH.

E 27278

161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N. High St. ST., 5-8 WARD)

2-FULL NAME Ralph Fonciti

(a) RESIDENCE NO. 215 N. High St ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1927

7 AGE: Years ... Months ... Days ... If LESS than 1 day, 8 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 0 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Sam Fonciti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Nettie Bianco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant C H Weckham M.D.

(Address) Johns Hopkins Hospital

15 - 1927 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1927, to Oct. 12, 1927, that I last saw him alive on Oct. 12, 1927, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C H Weckham, M. D.

11-8, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: NOV 19

20 UNDERTAKER

ADDRESS

TION IS very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27279

E 27279

CERTIFICATE OF DEATH

38

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Perry

(a) RESIDENCE NO. 1810 Hillen Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	03			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER Charles Perry

11 BIRTHPLACE OF FATHER (City or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Stipie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14 Informant

(Address) Records

15 Filed ..... 19 ..... Registrar

9-1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31/ 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1927 to Nov 3, 1927, that I last saw him alive on Nov 3, 1927, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

aortic insufficiency - syphilis

myocarditis

multiple neoplasms of bones

(duration) yrs. 3 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General & Local

(Signed) C. Holland Lloyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER Commissioner of Health. ADDRESS

BALTIMORE CITY HOSPITALS

UNIVERSITY OF MARYLAND

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27280

CERTIFICATE OF DEATH.

E 27280

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 19-28 Ward)

2-FULL NAME Mrs Catherine Gilchrest

(a) RESIDENCE NO. 1616 Lemon St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 6th 1870

7 AGE: Years 57 | Months 1 | Days 1 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore - Md

PARENTS

10 NAME OF FATHER Patrick Hayes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mason

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland.

14 Informant Mr Leo Gilchrest

(Address) 402 S Fulton Ave

15 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 11-7-27

17 I HEREBY CERTIFY, That I attended deceased from 8-12, 1927, to 11-7, 1927, that I last saw h[illegible] alive on 11-7, 1927, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray

(Signed) Francis L. Padaghacca, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial: Nov 10 1927

20 UNDERTAKER: John J Cowan & Son ADDRESS: 901 Fallsway

Very Important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 27281

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27281

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto City Hospital ST. 2-4 WARD)

2-FULL NAME John W. Frazier

(a) RESIDENCE (No. 3113 S Carlle ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: late Leona Frazier

6 DATE OF BIRTH (month, day, and year): Oct 18 1872

7 AGE: 55 Years | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John C Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Julia Brauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Edna Younger
(Address): 908 W Saratoga St

15 Filed NOV 9 - 1927, 19 C. HAMPSON JONES, M. D. Registrar.
By ARK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-6-, 1927 to Nov. 8, 1927

that I last saw him alive on ....., 19..

and that death occurred, on the date stated above, at 5-45 am

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Cerebral Hemorrhage ..... ds.

CONTRIBUTORY
(Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W Bluecher, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel

DATE OF BURIAL: Nov 11 1927

20 UNDERTAKER: Chenowith & Son

ADDRESS: 3615 Chestnut

TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 27282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

147

E 27282

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Woman's Hospital St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Annie E. Mizell

(a) RESIDENCE NO. Hamilton, N.C. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 14 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher.

(b) General nature of industry, business, or establishment in which employed (or employer) 568

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) N.C.

PARENTS

10 NAME OF FATHER H.H. Mizell

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N.C.

12 MAIDEN NAME OF MOTHER Annie Marcan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N.C.

14 Informant Hospital Record.

(Address)

15 [illegible] C. HAMPSON JONES, M. D.

Registrar

9 - 1927

Phy Visiting

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1927, to Nov. 9, 1927, that I last saw her alive on Nov 9, 1927, and that death occurred, on the date stated above, at 12:50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast, st. & spinal metastases. (8-10 dorsal)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia. Toxemia.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death? Not known.

Did an operation precede death? Yes Date of May 30, 1927 +

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) H. H. Mizell, M. D.

11/2, 1927 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Williamston N.C.	Nov 9 1927
20 UNDERTAKER	ADDRESS
A. W. Myers & Son	Williamston

(over) +

OF DEATH in plain terms. Do not use abbreviations or terms of doubtful meaning. Be sure that all questions are answered so far as may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 27283 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27283

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3513 Claremont ST. 27-37 WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R North

(a) RESIDENCE NO. 3513 Claremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Lena North

6 DATE OF BIRTH (month, day, and year) May 8 1853

7 AGE: Years 74 Months 6 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Continental Can

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward North

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Matilda Townsend

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Celia N Daubert (Address) 3510 Claremont

15 FILED Nov 9 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Nov 7, 1927, that I last saw h/M alive on Nov 7, 1927, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

from history (duration) One yrs. mos ~~20~~ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O K Mathews, M. D.

Nov 9, 1927 (Address) 3000 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Nov. 10 1927

20 UNDERTAKER: Mrs Albert E. Fuller ADDRESS: 4806 Harford ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

27284

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Johnson

(a) RESIDENCE NO. 28 Norris St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Thomas Johnson

6 DATE OF BIRTH (month, day, and year) Oct 2. 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	20	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0"7

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Owen Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gertrude Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Owen Hall

(Address)

15 Filed 11 19 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1927, to Nov 8, 1927, that I last saw h[illegible] alive on Nov 8, 1927 and that death occurred, on the date stated above, at 5 30 p m

The CAUSE OF DEATH* was as follows:

Meningitis Pneumococcic

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Lumber puncture daily Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Myron G Tull, M. D

11/9, 1927 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 10 1927
20 UNDERTAKER	ADDRESS
Saint Eaton	Balto

THON is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27285

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27285

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospitals 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Cherry

(a) RESIDENCE NO. 1209 Whitelock ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE: Years 79 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Vaudie Cherry

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Jennie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Wm Charlie Cherry

(Address) Canada Ont.

15 Filed 1927. 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6-1927

17

I HEREBY CERTIFY, That I attended deceased from 8-23, 1927, to 11-6-, 1927

that I last saw h alive on 11-6-, 1927

and that death occurred, on the date stated above, at 6.15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Clarence M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 10 1927

20 UNDERTAKER: Samuel Easton — ADDRESS 916 E Fayette Ave.

THIS is very important! See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 27286

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27286

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. BALTIMORE CITY HOSPITALS ST., 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman DeMar.

(a) RESIDENCE No. 120 Arch. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ?. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louise DeMar.

6 DATE OF BIRTH (month, day, and year) ? 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas.

PARENTS

10 NAME OF FATHER Benny DeMar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Julia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant (Address) Records

15 Filed NOV 9 - 1927, 19.....

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/ 8/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1927 to Nov. 8, 1927.

that I last saw h alive on Nov. 9, 1927

and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

Aneurism of thoracic aorta. Syphilis. Myocarditis. Chronic & acute.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General & Sub

(Signed) C. Hampson Jones M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem —	Nov 10 1927
20 UNDERTAKER	ADDRESS 916
Barnett Easton & Co	

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27287 ✓ 117 E 27287

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Bon Secours Hospital St. 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Key Jenkins

(a) RESIDENCE NO. 106-E-Chase-St. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S. If of foreign birth? 64 yrs. 5 mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George C. Jenkins

6 DATE OF BIRTH (month, day, and year) June-?-1843

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	84	5	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) LaFourche

(State or country) Louisiana

PARENTS

10 NAME OF FATHER Philip Barton Key

11 BIRTHPLACE OF FATHER (City or town) unknown

(State or country) unknown

12 MAIDEN NAME OF MOTHER Maria Sewall

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country) unknown

14 Informant Mrs. Ral Parr (daughter)

(Address) GreenSpringValley, Md.

15 NOV 9 1927 19 C. HARRISON JONES, M. D. Registrar

Per RCB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 November 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1927, to Nov 8, 1927,

that I last saw h.e alive on Nov. 8, 1927,

and that death occurred, on the date stated above, at 10 10 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

Chronic Cystitis & Pyelitis

Chronic Appendicitis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Appendicitis with Peritoneal Irritation

(duration) yrs. mos. 11 ds.

18 Where was disease contracted

If not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George O. Eaton, M. D.

, 19 (Address) Bon Secours Hosp'l.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — Date of Burial Nov-10-27 19

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 27288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27288

1-PLACE OF DEATH

REGISTERED NO. 1349

City of BALTIMORE: (No. Tudor Hall Apts. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Elisabeth Webb Levering

(a) RESIDENCE NO. Tudor Hall Apts. St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 3 mos. 3 ds. How long in U. S. if of foreign birth? 71 yrs. 3 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick A. Levering

6 DATE OF BIRTH (month, day, and year) August-5-1856

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	71	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. P. Webb

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Georgianna Deford.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mr. F. A. Levering Jr., (son)

(Address) 304-Wendover-Road, City.

15 Filed [illegible] - 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9- 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov-1- 19 27 to Nov 9- 19 27

that I last saw h[illegible] alive on Nov 9- 19 27

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Diabetic Infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Nov 9, 19 27 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial: Nov-10- 19 27

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

OF DEATH in plain terms, so that it may be properly classified. Each statement of occupation is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 27289

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 27289

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 203-Tunbridge-Road St. 27-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Charles Edmund Simon

(a) RESIDENCE NO. 203-Tunbridge-Road St. Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 1 mos. 16 ds. How long in U. S. if of foreign birth? 61 yrs. 1 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lina Simon

6 DATE OF BIRTH (month, day, and year) September-23-1866

7 AGE	Years	Months	Days
	61	1	16 15

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Professor and Teacher at

(b) General nature of industry, business, or establishment in which employed (or employer) School of Hygiene at

(c) Name of employer Johns Hopkins Hospital 068

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Simon

11 BIRTHPLACE OF FATHER (City or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helene Kirchner

13 BIRTHPLACE OF MOTHER (city or town) ? ? ?
(State or country) Germany

14 Informant Caroline Simon (wife)
(Address) 203-Tunbridge Road, City.

15 1927 ... 19 ... RRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8, 19 27

17 I HEREBY CERTIFY, That I attended deceased from ..., 19 17, to November 8, 19 27,

that I last saw h/m alive on November 8, 19 27,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis with auricular fibrilation

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral embolus (left sub mal Cyanosis

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted Baltimore Md
if not at place of death? 203 Tunbridge Road

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Electrocardiogram, Neurological examination after death

(Signed) Chas Cl[illegible]d, M. D.

. 19 (Address) 222 Woodbourne Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	Nov-10-27 19
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)	ADDRESS 106 W. NORTH AVE

Property classified on plan of lots. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27290

CERTIFICATE OF DEATH

91-082

E 27290

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1600 Webster St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wallace Durall

(a) RESIDENCE NO. 1600 Webster St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Widower.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Hester Durall

6 DATE OF BIRTH (month, day, and year) May 22 1849

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	78	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. W. Durall

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Albert Durall

(Address) 204 E. 31st St

15 Filed C. HAMPSON JONES, M. D. Registrar

By 1927 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

November 7 27

17 I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1927, to Nov 7, 1927,

that I last saw h.... alive on Nov 7, 1927,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteria sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Street, M. D.

11/9. 1927 (Address) 445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — Date of Burial Nov. 10 1927

20 UNDERTAKER Margaret A. Flynn — ADDRESS 1422 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27291

CERTIFICATE OF DEATH.

90 E 27291

1-PLACE OF DEATH

City of BALTIMORE: (No. 606 W. Hamburg St. St. 21-24 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia A. McGee.

(a) RESIDENCE NO. 606 W. Hamburg St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 7 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed or divorced (or) WIFE of XXXXXXXXXXXX Thomas E. McGee.

6 DATE OF BIRTH (month, day, and year) March 20, 1879.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Louis A. Loos.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Johanna Kreiss.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Thomas E. McGee. (husband)

(Address) 606 W. Hamburg St.

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) November 7, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

11/9 1927 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. Date of Burial Nov. 10 1927

20 UNDERTAKER Margaret L. [illegible] ADDRESS 1422 Light

very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Mercer

E 27292 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 27292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1035 S Sharp Street 23-31 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Marie Mercer

(a) Residence No. 1035 S. Sharp St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 31 1927

7-AGE yrs. 3 mos. 6 ds. If LESS than 1 day hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Md (State or Country).

PARENTS

10-NAME OF FATHER, James Ebron

11-BIRTHPLACE OF FATHER (city or town) Va (State or Country).

12-MAIDEN NAME OF MOTHER, Viola Mercer

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country).

14-Informant Anne Mercer

(Address) 1035 Sharp St

15-Filed NOV 10 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 7 1927

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1927 to Nov 7 1927

that I last saw her alive on Nov 7 1927

and that death occurred, on the date stated above, at 11 A, m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) — yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Observation & Symptoms

(Signed) Chas. H. Hopkins M. D.

Nov 8 1927 Address) 712 S Sharp St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Nov 10 1927

20-UNDERTAKER, John Bloom & Son ADDRESS 108 N. Liberty

Cor.—12-9-25—A Co.—200 Bks.

E 27293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27293

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2603 W. North Ave. St.) Ward)

2-FULL NAME Lauretta Croswell

(a) RESIDENCE NO. 2603 W. North Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Croswell

6 DATE OF BIRTH (month, day, and year): Oct 8, 1869

7 AGE — Years: 58 — Months: 1 — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Spurrier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Ella M. Manly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Ella Spurrier (Address) 811 E 22nd St

15 Filed NOV 10 1927 Per C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 8, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest, and from (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) No other disease

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

1927 (Address) 2572 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. d.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Nov 10. 1927

20 UNDERTAKER: Wm Cook ADDRESS 702 E North Ave

Very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 27294

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001

E 27294

REGISTERED NO.

1-PLACE OF DEATH St Joseph's Hospital

City of BALTIMORE: (No. 9-46 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Dietz

(a) RESIDENCE NO. 1704 Gorsuch Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte M. Dietz

6 DATE OF BIRTH (month, day, and year) June 4th 1876

7 AGE: Years 50 Months 10 Days 29 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER John Dietz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Charlotte M Dietz

(Address) 1704 Gorsuch ave

15 Filed NOV 10 1927 C. HAWOOD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1927, to Nov. 6, 1927

that I last saw him alive on Nov. 6, 1927

and that death occurred, on the date stated above, at 9.35 P m.

The CAUSE OF DEATH* was as follows:

Strangulated ventral hernia

Strangulated (7 days)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction & toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted at home

If not at place of death?

Did an operation precede death? yes Date of Nov 2

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) A Laurence Fahrney, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — Date of Burial Nov 10 1927

20 UNDERTAKER George F. Ruth — ADDRESS 1735 Harford Ave

very important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27295

CERTIFICATE OF DEATH

45 E 27295

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5II5 Edmondson Ave., St., 28th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gotlieb Kraft

(a) RESIDENCE NO. 5II5 Edmondson Ave., St. Ten Hills Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frieda (Nee Singelmann)

6 DATE OF BIRTH (month, day, and year)
Feb. 2, 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
69		9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oriental Rug Co.,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Gotlieb Kraft

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Gotlieb Kraft

(Address) 5II5 Edmondson Ave.

NOV 10 1927

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Nov. 9th 1927.

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927 to Nov 9th 1927

that I last saw him alive on Nov 8th 1927

and that death occurred, on the date stated above, at 4.05 a m.

The CAUSE OF DEATH* was as follows:

Bronchi Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum & Prostatic Gland

about (duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Protoscopic exam etc.

(Signed) Amelia V. Zimmerman, M. D.

, 19 (Address) 1805 W north ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

Date of Burial Nov. 11 1927

20 UNDERTAKER Harry A. Voltz

ADDRESS 5210 Edmondson Ave

IMPORTANT—Physician in charge of case is required to fill out and sign CERTIFICATE OF DEATH in plain terms, so that it may be properly understood. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27296

CERTIFICATE OF DEATH.

5 VE 27296

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 550 W. Biddle St. 17-24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Collins

(a) RESIDENCE. No. 550 W. Biddle St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leo Collins

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home.

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Georgia Collins (Address) 550 W. Biddle St.

15 Filed OCT 10 1924 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 7 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 28 ..., 19..., to NOV 7 ..., 19 24.

that I last saw h... alive on NOV 7 ..., 19 24.

and that death occurred, on the date stated above, at 1.01 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. Fulton, M. D.

19 NOV 7, 19 24 (Address) 550 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cem	11/10 1924
20 UNDERTAKER Samuel P. Hemsley	ADDRESS 678 W. Biddle

THIS is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Williams

HEALTH DEPARTMENT—CITY OF BALTIMORE

665

E 27297

CERTIFICATE OF DEATH.

E 27297

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Hospital St., (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Williams

(a) RESIDENCE NO. 2833 Reese St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1881

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto.Co.Md.

PARENTS

10 NAME OF FATHER Benj.Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto.Md.

12 MAIDEN NAME OF MOTHER Emma Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Agnus Williams.

(Address) 2833 Reese St.

15 [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/6 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism Chronic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Williams M. D.
(Coroner)

11/9 1927 (Address) 1532 Rockland Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasent rest Cem. Date of Burial: 11/10/27 19

20 UNDERTAKER: Mrs. A. G. Elliott ADDRESS: 1725 Eastland Ave

NOV 10 1927 C. HAMPSON JONES, M. D. Registrar

For

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 27298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-002
E 27298
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1100 Darley Ave St. 8-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanora Dumser

(a) RESIDENCE NO. 1100 Darley Ave St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23 1927

7 AGE Years Months Days 16 17 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frederick Dumser

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary McCarrigan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Frederick Dumser
(Address) 1100 Darley Ave

15 Filed 10 1927 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1927 NOV 9

17 I HEREBY CERTIFY, That I attended deceased from 10/1 1927, to 10/9 1927, that I last saw her alive on 10/9 1927, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? at birth

(Signed) Adam Miller M. D.

10/10 1927 (Address) 1500 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Aecidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: NOV 10 1927

20 UNDERTAKER: John F Penny — ADDRESS: 345 Light St

very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27299 E 27299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hollins Ferry Rd. ST. 25th WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Jackson Dixon

(Residence in Baltimore: No. Hollins Ferry Rd. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 18, 1870
(Month) (Day) (Year)

7-AGE, 56 yrs. 10 mos. 21 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paper cutter do
(b) General nature of industry, business, or establishment in which employed (or employer): Manufacturing Label

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Robert E. L. Dixon

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER Isabelle Travers

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret A. Dixon

(Address) Hollins Ferry Rd Lakeland

15- C. HAMPSON JONES, M. D.

Filed ... 191... Registrar.

NOV 10 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 9, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1927, to Nov 9 1927, that I saw h alive on Nov 9 1927, and that death occurred, on the date stated above, at 12 M

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) ? yrs. mos. ds.

(Signed) C. Hampson Jones M. D.

Nov 9, 1927 (Address) Lakeland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Nov. 12, 1927

20-UNDERTAKER John H. Denny — ADDRESS 715 Light St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27300

CERTIFICATE OF DEATH

REGISTERED NO. E 27300

1-PLACE OF DEATH

City of BALTIMORE: (No. 1918 Mt. Royal Terrace St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brewer Howard

(a) RESIDENCE NO. 1918 Mt. Royal Terrace St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	73	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in whirh employed (or employer) at Home

(r) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Robert Howard

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Stansbury

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mr. Sam Nixdorff

(Address) 1918 Mt. Royal Terrace

15 C. HAMPSON JONES, M. D.

Registrar

NOV 10 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1927, to Nov. 8, 1927,

that I last saw her alive on Nov. 8, 1927,

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis, due to perforation of Stomach Wall by Carcinoma of Same

(duration) about 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Usual

(Signed) H. Latrobe Ennalls, M. D.

Nov 10, 1927 (Address) 3945 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spare.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Lorraine Park Cemetery	Nov 11 1927
20 UNDERTAKER John F. Denny	ADDRESS 715 Lights

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27301

CERTIFICATE OF DEATH.

74-08 27301

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Towson

(a) RESIDENCE NO. 575 Hyatt St 575 Hyde St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary A. Towson

6 DATE OF BIRTH (month, day) and year) July 18th 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	54	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett & Hayward
(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country) Balto

PARENTS

10 NAME OF FATHER James Towson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Martha Green

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Mrs Towson
(Address) 575 Hyatt st

NOV 10 1927

C. HAMILTON JONES, M. D.

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day) Nov 8 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Paralysis
(duration) yrs. mos. 1 ds.

Nov 9 1927 Signed F. C. Grades M. D.
(Coroner)
(Address) 143 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Nov 11 1927

20 UNDERTAKER Sam Fields ADDRESS 1200 N Gilmor st

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

27302

CERTIFICATE OF DEATH.

28 E 27302

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1219 Washington Blvd St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H. O'Neal

(a) RESIDENCE NO. 1219 Washington Blvd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha A. O'Neal

6 DATE OF BIRTH (month, day, and year): July 4th 1896

7 AGE

Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
31	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: U R & Elec Co

9 BIRTHPLACE (city or town)

(State or country): Dacto

PARENTS

10 NAME OF FATHER: Chas E. O'Neal

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth B. Byrd

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Dacto

14 Informant: Bertha A. O'Neal

(Address): 1219 Washington Blvd

Filed NOV 10 1927. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 7th, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) 1 3/12 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos B. Norton M. D. (Coroner)

Nov 9th 1927 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where did disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — Date of Burial: 11-10 1927

20 UNDERTAKER: Bernard C Hank — ADDRESS: 1000 E Pacca St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27303

CERTIFICATE OF DEATH.

13 E 27303

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. WARD)

2-FULL NAME Lee Anderson

(a) RESIDENCE No. 1616 W. Carrollton Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Chas. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant

(Address) Private.

NOV 10 1927

C. HARROW JONES, M. D. Registrar

Per DHL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1927, to Nov. 7, 1927

that I last saw h[illegible] alive on Nov. 7, 1927

and that death occurred, on the date stated above, at 12:00 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia.- Duration undetermined.

(duration) yrs. mos 2 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gram's Stain

(Signed) C. Holmes Bruyn, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Ziona Cy

DATE OF BURIAL Nov 10 1927

20 UNDERTAKER Leonard (Master)

ADDRESS 65 Myrtle Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27304

CERTIFICATE OF DEATH.

12 4 E 27304

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospital ST., 34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Young

(a) RESIDENCE NO. 1508 E Lombard ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Benoon Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: City Hospital Records.
(Address)

15 Filed ..... 19 ..... C. H. ..... Registrar.

DUPLICATION

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6-1927

17

I HEREBY CERTIFY, That I attended deceased from 7-14-1927 to 11-6-1927

that I last saw her alive on 11-6-1927

and that death occurred, on the date stated above, at 6 15 p m

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Chronic Myocarditis

Chronic Interstitial Nephritis

(duration) Unknown

CONTRIBUTORY
(Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Signs

What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery

DATE OF BURIAL: Nov 10 1927

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Orleans St

Spec.—1-12-23—M&T—500 Bks.

E 27305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 27305
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Bethel ST., 7-4 WARD)

2-FULL NAME Hattie Saunders

(a) RESIDENCE NO. 517 N. Bethel ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Levin Shawell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown.

14 Informant Ventrus Saunders
(Address) 517 N. Bethel

15 Filed NOV 10 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-9-1927

17 I HEREBY CERTIFY, That I attended deceased from 2-2, 1926, to 11-9, 1927, that I last saw her alive on 11-9, 1927 and that death occurred, on the date stated above, at 1,30 P. m

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis

(duration) Don't know. yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Cargill, M. D.

11-10 1927 (Address) 611 N. Carolin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bury Cemetery — DATE OF BURIAL Nov 11 1927

20 UNDERTAKER Edward Bryan — ADDRESS 631 Orleans St

Spec.—12 9 25—A Co—200 Bks.

E 27306

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 27306

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 802 E Fayette St. 24-33 Ward)

2-FULL NAME William B. Geoghagan

(a) RESIDENCE NO. 802 E Fayette St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/27

7 AGE. Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	10 11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Geoghagan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ire.

12 MAIDEN NAME OF MOTHER Annie C Sunderland

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mr Henry Geoghagan

(Address) 802 E Fortaye.

Filed NOV 10 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9/27 19

17

I HEREBY CERTIFY, That I attended deceased from Nov 8/27 19 , to Nov 9/27 , 19 ,

that I last saw h.. alive on Nov 9/27 , 19 ,

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

Pneumococcus (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Signed) Nov 10/27 Henry B Kolb, M. D.

(Address) 1 W 34 Eyler

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Holy Cross adds 11/10/27

20 UNDERTAKER ADDRESS

John J Fahey Sons 1318 Light St

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27307 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St. 11-23 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ada Getz

(a) RESIDENCE NO. 1111 N. Fremont ST. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: married Dr. Charles Getz

6 DATE OF BIRTH (month, day, and year): Sept 25 1857

7 AGE: 70 Years | 1 Months | 13 Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): North Attleboro Mass.

PARENTS

10 NAME OF FATHER: Charles M. Eldred

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass

12 MAIDEN NAME OF MOTHER: Martha C. Eldred

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass.

14 Informant: Dr. Charles Getz
(Address): 111 W. Fremont St.

15 Filed NOV 10 1927 HARRY DAVIS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8. 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept 22. 1927. to Nov 8. 1927.
that I last saw h-r alive on Nov 8. 1927
and that death occurred, on the date stated above, at 10.05 p m.
The CAUSE OF DEATH* was as follows:

Convalyed carcinomatosis of abdomen.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia (duration) yrs. mos. 12. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes. Date of Sept 23 1927

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. F. Gwinn, Cotterdale M. D.

Nov 8. 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Nov 12 1927

20 UNDERTAKER: George A. Smith — ADDRESS 1332 Hollins

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27308

CERTIFICATE OF DEATH.

E 27308

1-PLACE OF DEATH 849 W. Fayette St 18-16 12 REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Grace Wittgenstein

(a) RESIDENCE No. 849 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Milton Wittgenstein

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
47	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John L. Feuerberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) United States

12 MAIDEN NAME OF MOTHER Matilda Fellinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Anna Morgan

(Address) Sister 849 W Fayette

15 Filed NOV 10 1927 T. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 7 1927, to Nov. 9 1927, that I last saw h alive on Nov. 8 1927, and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency hyper-tension, nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of ——

Was there an autopsy? no

What test confirmed diagnosis? ——

(Signed) L. C. Gabriel, M. D.

(Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Saint Vincents Cem	Nov 11 1927
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

CAUSE OF DEATH to be filled in by physician, as far as known, at time of certificate. See instructions on back of certificates.
TION is very important.

Cor.—12-9-25—A Co—200 Blks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27309

CERTIFICATE OF DEATH.

18-003

E 27309

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hosp. (Street) 7 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Collins

(a) RESIDENCE NO. 1400 W. Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Feb 1855

7 AGE: Years: about 72 — Months: 9 — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Mass.

PARENTS

10 NAME OF FATHER: Job Collins

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Mass.

12 MAIDEN NAME OF MOTHER: Hanah Price

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Mass

14 Informant: Mrs Mary Forestal

(Address) 1400 W. Lexington St

15 Filed NOV 10 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Nov. 8th 1927

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest or no inquest.) thereon and from the evidence obtained by said Inquest (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) accidentally by Auto

(Confirmed) yrs. mos. da.

(Signed) Thos. B. Koby M. D.

Nov 9 1927 (Address) Curtis Bay Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery Date of Burial: Nov 10 1927

20 UNDERTAKER: George J Smith ADDRESS: 1532 Hollins

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 135 E 27310

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas W Seaman

(a) RESIDENCE No. Carbondale Pa. ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER John W Seaman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Stivers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 NOV 10 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1927, to Nov 9, 1927, that I last saw h. (M.) alive on Nov 9, 1927, and that death occurred, on the date stated above, at 1130 m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Carbondale Pa

Did an operation precede death? Yes Date of Nov 2-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical Picture

(Signed) Robert W Mackay, M. D.

Nov 9, 1927 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carbondale Pa. DATE OF BURIAL Nov 10 1927

20 UNDERTAKER Chas. G. Black ADDRESS 742 W North ave

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 27311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43

E 27311

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 127 S. Poppleton St. 18-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Blair.

(a) RESIDENCE NO. 127 S Poppleton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lonella V. Finn.

6 DATE OF BIRTH (month, day, and year) Aug 16 - 1873

7 AGE: Years 54, Months 2, Days 23. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dresser.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Stuyler Co.

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Blair.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Wessel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Mrs Lonella B. Finn

(Address) 127 S Poppleton St

Filed NOV 10 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8th 1927.

17 I HEREBY CERTIFY, That I attended deceased from 11/8 1927 to 11/8 1927, that I last saw h.... alive on 11/8 1927, and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Jaw (about)

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death!

Did an operation precede death! Date of

Was there an autopsy! J.H Hos.

What test confirmed diagnosis!

(Signed) Bernard Finn, M. D.

11/9, 1927 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. Date of Burial: Nov 11th 1927

20 UNDERTAKER: John F Howard & Son ADDRESS: 901 Eutaw

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27312

CERTIFICATE OF DEATH.

62 E 27312

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 Barclay ST. 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice L Malstrom

(a) RESIDENCE No. 2009 Barclay St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs 10 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10-27

7 AGE: Years | Months: 3 2 | Days: 29 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm J Malstrom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Katie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston

14 Informant Mr Malstrom

(Address) 2009 Barclay St

15 Date received NOV 10 1927 E. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1927, to Nov 9, 1927, that I last saw h[illegible] alive on Nov 9, 1927 and that death occurred, on the date stated above, at 3 P m

The CAUSE OF DEATH* was as follows:

Enlargement Thymus Gland.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Respiratory Embarrassment

Asphyxia (duration) yrs. mos. 10 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wally W. White Jr. M. D.

, 19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: 11/10/27

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford Ave

Spec.–7-17-26—A Co.—200 Bks.

E 27313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 27313

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1545 Ramsey St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Columbus Werfield

(a) RESIDENCE NO. 1545 Ramsey St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. d-

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Rebecca Werfield

6 DATE OF BIRTH (month, day, and year) June 13, 1840

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	87	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua Warfield

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Griffon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant William P. Warfield

(Address) 1533 Ramsey Street

15 Filed 19 C. HARRISON JONES, M. D.

Registrar

NOV 10 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

November 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1927, to Nov 8, 1927,

that I last saw him alive on Nov 8, 1927,

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) James F. Ligon M. D.

11/9 19 27 (Address) 1729 W. Lombard Street

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
National Cemetery	11/11/27

20 UNDERTAKER Robert B. Cook ADDRESS 2033 W. Baltimore St

Property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27314

74-E 27314

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1126 Leadenhall St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gurdon C. Sill

(a) RESIDENCE NO. 1126 Leadenhall St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Nora Sill

6 DATE OF BIRTH (month, day and year) May 1, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	70	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Veterinarien

(b) General nature of industry, business, or establishment in which employed (or employer) Ost

(c) Name of employer

9 BIRTHPLACE (city or town) West Nottingham,

(State or country) Cecil County, Maryland

PARENTS

10 NAME OF FATHER Amos Sill

11 BIRTHPLACE OF FATHER (City or town) Cecil Co.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Weir

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Delaware

14 Informant James M. Sill

(Address) 1124 Leadenhall St.

Filed NOV TO 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 9, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1927, to November 9th, 1927, that I last saw him alive on Nov. 6th, 1927, and that death occurred, on the date stated above, at 9.00 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Grade of Brain)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Harper, M. D.

, 19 (Address) 817 Park Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bay, West Nottingham, Cecil Co., Md. Date of Burial 11/11 1927

20 UNDERTAKER Joseph B Cook ADDRESS 1000 W. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

E 27315

HEALTH DEPARTMENT—CITY OF BALTIMORE

100E 27315

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 N. Hamilton Ave. St., 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Geiss

(a) RESIDENCE NO. 8 N Hamilton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of John Geiss

6 DATE OF BIRTH (month, day, and year): 2/2 1852

7 AGE: Years 75 Months 9 Days 7

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Otto Geiss

(Address) 153 N Pulaski St

Filed ..... 19 ..... HARRISON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Nov 9 1927

17 I HEREBY CERTIFY, That I attended deceased from November 4 1927 to November 9 1927

that I last saw her alive on November 8th 1927

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis Exhaustion

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard Woodruff M. D.

11/10/1927 (Address) 530 E. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

Date of Burial: Nov 11 1927

20 UNDERTAKER: John Ulsh

ADDRESS: 2 [illegible]

NOV 10 1927

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

27316

CERTIFICATE OF DEATH.

91-002

E 27316

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 703 N Chester ST. 6-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernhard Mueller

(a) RESIDENCE No. 703 N Chester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonetta Mueller

6 DATE OF BIRTH (month, day, and year) March 5 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Nicholas Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Kurtz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Antonetta Mueller

(Address) 703 N Chester St

15 Witness

NOV 10 1927 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Nov 8, 1927, that I last saw him alive on Nov 8 1927, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What tests confirmed diagnosis? Phy Ex

(Signed) W C Stadel, M. D.

Nov 9 1927 (Address) 1430 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Nov 11 1927

20 UNDERTAKER John Merrick

ADDRESS Loc Orleans

Spec. 1-12-23—M&T—500 Blks.

E 27317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 E 27317

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2808 Orleans St. (ST.) 6-11 (WARD)

2-FULL NAME Thomas J. Kernan

(a) RESIDENCE NO. 2808 Orleans St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 10, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Steward

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —— O/H

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Kernan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. Josephine Owens 2808 Orleans St.

15 Filed 10 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 26 1922 to Nov 8 1927

that I last saw h alive on Nov. 7 1927

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hemorrhage.

Followed by Pneumonia Lobaris

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J. Seeling, M. D.

Nov 9 1927 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 11 1927

20 UNDERTAKER John A. Moran — ADDRESS 3005 E. Pratt St.

TION IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27318

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27318

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 308 N Robinson ST. 6-11 WARD)

2-FULL NAME Mary A Sattler

(a) RESIDENCE NO. 308 N Washington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D Sattler

6 DATE OF BIRTH (month, day, and year): Aug 14 1851

7 AGE — Years: 76 Months: 3 Days: 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jerome H Sattler

(Address) 245 N Chapel Ave

15 Filed 10 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1927, to Nov 9, 1927, that I last saw her alive on Nov 9, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) M. L. Mayer, M. D.

11/10, 1927 (Address) 2612 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 11 12 1927

20 UNDERTAKER: Geo Cook — ADDRESS: 502 E North Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27319

CERTIFICATE OF DEATH.

90 E 27319

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4503 Belmont Ave ST. 37-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin G Shipwash

(a) RESIDENCE No. 4503 Belmont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Carrie Shipwash

6 DATE OF BIRTH (month, day, and year) Jan 2, 1873

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
55	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rogan & Weber

9 BIRTHPLACE (city or town) (State or country) [illegible] S. C.

PARENTS

10 NAME OF FATHER Albert Shipwash

11 BIRTHPLACE OF FATHER (city or town) [illegible] S. C.

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible] S. C.

14 Informant Robert A Shipwash

(Address) 4503 Belmont Ave

15 Filed 10 1927 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1927, to Nov 9, 1927, that I last saw h[illegible] alive on Nov 9, 1927, and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Chronic Endocarditis (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan B Lumsden, M. D.

11/9, 1927 (Address) 1811 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winston-Salem, N C

DATE OF BURIAL 11/1 1927

20 UNDERTAKER [illegible]

ADDRESS [illegible] E North Ave

Spec.–7-17-26—A Co.—200 Bks.

E 27320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 27320

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Scanglutz

(a) RESIDENCE NO. 4th Ave & 35th St Oswego Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	W. divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min..
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Solicitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant

(Address) Records

15 Filed [illegible] C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/ 1927

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to Nov. 8, 1927,

that I last saw him alive on Nov. 8, 1927,

and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 4 mos. 9 da.

CONTRIBUTORY (Secondary) hypertrophic cirrhosis

(duration) 7 yrs. mos. da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) C. Nelson Snyder, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Disinterred and buried

Date of Burial Nov. 12 1927

20 UNDERTAKER Wm. Cook

ADDRESS 502 E. North Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27321

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27321

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 Hawthorn Rd ST.) (7-53 WARD)

2-FULL NAME Gertrude L. Lander

(a) RESIDENCE NO. 412 Hawthorn Road ST. Roland Park WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel M. Lander

6 DATE OF BIRTH (month, day, and year): Jany 6 - 1844

7 AGE: Years 83; Months 10; Days 3; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Huntingdon W. Va

PARENTS

10 NAME OF FATHER: Wm P. Crabtree

11 BIRTHPLACE OF FATHER (city or town) (State or country): Seneca

12 MAIDEN NAME OF MOTHER: Amanda Ann Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greenbrier Co W. Va

14 Informant: Percy W. Lander

(Address) 412 Hawthorn Rd

DEC 10 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1927, to Nov 8, 1927, that I last saw h[illegible] alive on Nov 8th, 1927 and that death occurred, on the date stated above, at 9 00 m

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary): Chronic nephritis

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Johnson Buck M. D.

11/9, 1927 (Address) 414 S. Club Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 10 1927

20 UNDERTAKER: W. J. Tuckerdorf — ADDRESS: [illegible]

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27322

CERTIFICATE OF DEATH.

129 E 27322

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2532 E Baltimore St., 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Koebrich

(a) RESIDENCE NO. 2532 E Baltimore St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 6 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mes. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of William Koebrich

6 DATE OF BIRTH (month, day, and year): May 2 1860

7 AGE — Years: 67 — Months: 6 — Days: 6 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Chas Schwartzhaupt

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Myer

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md

14 Informant: Chas C. Koebrich

(Address) 3714 Greenmount Ave

15 Filed: C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1927, to Nov 8, 1927, that I last saw her alive on Nov 8, 1927, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular-renal disease - arterio-sclerosis & hypertension

Myocarditis Chronic - Chr. nephritis -

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Pulmonary oedema - anaemia

(duration) yrs. mos. 2½ ds.

18 Where was disease contracted? —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physician - Wife

(Signed) John F Heaney, M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetary Date of Burial Nov 11 1927

20 UNDERTAKER: Wm J Tucker & Sons ADDRESS Hot Balto

Very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27323

CERTIFICATE OF DEATH

100-001 E 27323

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3204 E White Ave St., 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Thomas Bassett

(a) RESIDENCE NO. 3204 E White Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M Davis

6 DATE OF BIRTH (month, day, and year) Mar 30 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
–	71	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Galena

(State or country) Kent Co Md

PARENTS

10 NAME OF FATHER Hurley Bassett

11 BIRTHPLACE OF FATHER (City or town) unknown

(State or country)

12 MAIDEN NAME OF MOTHER Matilda Bennett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Ida M Davis

(Address) 3204 E White ave.

10 1927 C. HAMPSON JONES, M. D. Registrar

Pw R E S

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 8th, 1927, to Nov 10th, 1927, that I last saw him alive on Nov 9th, 1927, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. L. Gordy, M. D.

11-10, 1927 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Parkwood Cemetery	Nov 12 1927.
20 UNDERTAKER	ADDRESS
Walter R. McNamee	4 mi Falls Rd.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27324

CERTIFICATE OF DEATH.

31 E 27324

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ..... ST., 713 WARD)

2-FULL NAME Nellie Wilson

(a) RESIDENCE NO. 1058 E. Monument st. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of Coleman Wilson
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) North Carolina

PARENTS

10 NAME OF FATHER Essa Johnson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Katie Randolph

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) North Carolina

14 Informant Hospital Records
(Address)

15 Filed 11 1927, 19 Registrar C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 19 27, to Nov. 7, 19 27, that I last saw h[illegible] alive on Nov. 7, 19 27, and that death occurred, on the date stated above, at 9 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) No Laryngitis, Enteri[illegible]

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) L E Madden M. D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL Nov-11 1927

20 UNDERTAKER Thos. J. Locke ADDRESS 1302 Jefferson

Spec.—1-10-21—M&T—1500 Bks.

Collins ✓

E 27325

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27325

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Cook Ave., Raspeburg, Md. St. 27-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Collins

(a) RESIDENCE NO. 2 Cook Ave., Raspeburg, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida C. Collins

6 DATE OF BIRTH (month, day, and year) March 11, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	3 7	20 28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Michaels
(State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Collins

11 BIRTHPLACE OF FATHER (city or town) New Orleans
(State or country) Louisiana

12 MAIDEN NAME OF MOTHER Johanna Pfister

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Ida C. Collins
(Address) 2 Cook Ave., Raspeburg, Md.

15 Filed NOV 11 1927, 19 Per C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 19 27

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8th, 19 27, to November 9th, 19 27, that I last saw h in alive on Nov. 8th, 19 27, and that death occurred, on the date stated above, at 1:15 A. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos 3 Hrs. ds.*

CONTRIBUTORY (Secondary) Arterio-sclerosis (This attack)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

11, 9 19 27 (Address) A. L. Wilkinson, 6713 Belair Rd., Raspeburg, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Nov. 12 '27

UNDERTAKER Frederick Lassahn & Sons — ADDRESS Fulkston

CAUSE OF DEATH must be stated plainly, and in detail. See instructions on back of certificates. TION is very important.

Spec.–7-17-26—A Co.—200 Bks.

E 27326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51 E 27326

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1712 Dan. per St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Annie Armstrong

(a) RESIDENCE NO. 1712 Forster St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Armstrong

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 56 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town): Salem, Md.

(State or country)

PARENTS

10 NAME OF FATHER: Cornelius Curtis

11 BIRTHPLACE OF FATHER (City or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Harriet Curtis

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: Edward J. Armstrong

(Address) 211 Fort Avenue

15 Filed NOV 11 1927

C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 19 27 to Nov 9th, 19 27.

that I last saw h.. alive on Nov 9th, 19 27.

and that death occurred, on the date stated above, at 1 00 m.

The CAUSE OF DEATH* was as follows: Acute Arterial Hemorrhage

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cardio Arrhythmia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) M. C. Clark, M. D.

, 19 (Address) 1712 Forster St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mountain View, Hartford Co. Md. Date of Burial 11/12 1927

20 UNDERTAKER: Byron D. Wright ADDRESS 1218 McElderry St.

Very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 27327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27327

1-PLACE OF DEATH Maryland Penitentiary

City of BALTIMORE: (No. 954 Forrest St., 10th Ward)

Registered No.

2-FULL NAME Alfred Fredrick Simms

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. Route 8 Box 238 Prince George Co St., Ward. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. C

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 16, 1908

7-AGE. 19 yrs. 5 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer Kauffman Lumber Co.

9-BIRTHPLACE (city or town) Prince George Co.
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER. George Hunton Simms

11-BIRTHPLACE OF FATHER (city or town) Prince George Co
(State or Country) Md.

12-MAIDEN NAME OF MOTHER. Rosie Jackson

13-BIRTHPLACE OF MOTHER (city or town) Richmond Va.
(State or Country)

14-
(Informant) Alfred F. Simms
(Address) 954 Forest St.

15-
Filed 11 1927 C. HAMPSON JONES M.D. Registrar.
By [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11-11-1927

17- I HEREBY CERTIFY, That I attended deceased from August 19 27 to November 11 19 27
that I last saw h im alive on November 11 19 27
and that death occurred, on the date stated above, at 12 20 A m.
The CAUSE OF DEATH* was as follows:
Dislocation of 5th Cervical vertebrae
Hanged by order of the court.
(Duration) Immediate yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas W. Edmunds M. D.
19 (Address) 454 Forest St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Washington D.C.	10 11 1927
20-UNDERTAKER.	ADDRESS
James T. Handley	478 Reisterstown

Spec.—I-10-21—M&T—1500 Bks.

E 27328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-00 E 27328

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1028 McCulloh ST. (or WARD) 11-24

2-FULL NAME Otha R. Hood

(a) RESIDENCE No. 1028 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26, 1890

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
37	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Robt J. Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Hattie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Robt C. Hood

(Address) 1028 McCulloh St.

15 Filed NOV 11 1927 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1927.

17

I HEREBY CERTIFY, That I attended deceased from Nov 8th 1927. to Nov 9 1927.

that I last saw him alive on Nov 9th 1927.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Lobar-Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harvey J Brown, M. D.

Nov 9 1927 (Address) 1916 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cem

DATE OF BURIAL Nov 11 1927

20 UNDERTAKER: Samuel Stanley

ADDRESS 1078 Druid

TION is very important. See instructions on back of certificates.

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27329

1-PLACE OF DEATH

101-001 E 27329

REGISTERED NO.

City of BALTIMORE: (No. 427 W. Conway St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jordan

(a) RESIDENCE NO. 427 W Conway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Guest Jordan

6 DATE OF BIRTH (month, day, and year): — 1840

7 AGE: Years 38 (37) Months — Days —

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Catch Boat Crew

(b) General nature of industry, business, or establishment in which employed (or employer): Oyster Packing

(c) Name of employer: Maryland Glass Factory

9 BIRTHPLACE (city or town): Danville

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country)

14 Informant: Blanche Marshall

(Address): 626 W Montgomery

15 Filed NOV 11 1927 19 C. HAMPTON JONES, M. D. Registrar

Dur

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/9 1927

17 I HEREBY CERTIFY, That I attended deceased from 11/8, 1927, to 11/9, 1927, that I last saw h[illegible] alive on 11/9, 1927, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

..... (duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Dan Francken, M. D.

11/10. 1927 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — Date of Burial Nov 12 1927

20 UNDERTAKER: Samuel Hemsley — ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27330

CERTIFICATE OF DEATH.

101-001

E 27330

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Druid Hill Ave. ST. 14-20 WARD)

2-FULL NAME Elizabeth Moore Hatton

(a) RESIDENCE No. 1424 Dr. Hill Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Samuel Hatton

6 DATE OF BIRTH (month, day, and year) Dec 6-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Morris Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Martha Davies (Daughter)

(Address) 1424 Druid Hill Ave.

15 Filed NOV 11 1927 C. HAMILTON JOHNSON, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 17, 1927, to Nov 9 - 1927, that I last saw h~~e~~ alive on Nov 9 - 1927 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Rheumatoid Arthritis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) James Brown, M. D.

11/9, 1927 (Address) 1837 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL

Ft. Auburn Cemetery | Nov 12 1927

20 UNDERTAKER Samuel Hawley | ADDRESS 1711 Bolton

FROM IS VERY important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

27331 E

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 27331

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hospital for the Women of Maryland St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Rickus Schumacher

(a) RESIDENCE NO. 506 Harwood Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 7 mos. 16 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 24 1866

7 AGE — Years: 61 — Months: 7 — Days: 16 — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Masseuse

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Caesar Schumacher

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant: Miss Isabel Lazarus

(Address) 506 Harwood ave.

15 Filed NOV 11 1927 C. HAMPSON JONES, M. D. Registrar

Per R.P.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

11-10-27

17 I HEREBY CERTIFY, That I attended deceased from ——, 19 27, to 11-10, 19 27, that I last saw h ER alive on 11-10, 19 27, and that death occurred, on the date stated above, 2.30 P m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

MYOCARDIAL INSUFFICIENCY

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. Cem

Date of Burial: 11/12 1927

20 UNDERTAKER: Henry W. Jenkins Sons Co

ADDRESS Orchard & McCulloh

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27332

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. E 27332

1-PLACE OF DEATH

City of BALTIMORE: (No. 540 Wilson 14-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Smith

(a) RESIDENCE NO. 540 Wilson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ William Smith

6 DATE OF BIRTH (month, day, and year) Feb 26, 1861

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	66	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Washington

(State or country) D C.

PARENTS

10 NAME OF FATHER Isaac Talbott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Washington D C.

12 MAIDEN NAME OF MOTHER Georgiana Dunbar

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Washington D C.

14 Informant Owen A. Smith

(Address) 540 Wilson St

Filed NOV 1 1927, 19

C. HAMILTON JONES, M. D.

Per

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1927, to Nov 8, 1927, that I last saw ~~her~~ alive on Nov 7, 1927 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Wellman Trent, M. D.

11 8, 1927 (Address) 928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

Date of Burial 11-11 1927

20 UNDERTAKER George T. C. Gibson

ADDRESS 1735 Druid Hill Ave

V 11 1927

Property of Baltimore City Health Department. Public statement of OCCUPATION is of great importance in death records, as that is often the only source of certificates. See instructions on back of certificate. Very important.

Cor.—12-9-25—A Co.—200 Bks.

E 27333

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27333

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Bayst. Hospital St. Ward)

2-FULL NAME James Edgar Bright

(a) RESIDENCE NO. 1224 D. Hill Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 16-1907

7 AGE: Years 20 Months 6 Days 23 IF LESS than 1 day ___hrs. or ___min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: James M. Bright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Bruce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): James M. Bright 1224 D. Hill Ave

Filed NOV 11 1927 C. HAMPSON JONES, M. D. Registrar

By ___

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 9 192 7

17 I HEREBY CERTIFY, That I ~~viewed the body of~~ ~~James E. Bright~~ Deceased, ~~held an~~ Inquiry thereon and from the evidence obtained by said Inquiry find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism following operation for Tonsils & Adenoids

(Duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Sinusitis

(duration) yrs. mos. ds.

Signed G C Yates M. D.

11/27, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Date of Burial 11/12 1927

20 UNDERTAKER: Wm. Geo. H. Holland ADDRESS 1651 Druid Hill Ave

very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27334 (upper right) 117 ✓ E 27334

REGISTERED NO.

E 27334
1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St., 8-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rose Nelson

(a) RESIDENCE NO. 2800 Clifton Park Terrace St. 8th Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael J. Nelson

6 DATE OF BIRTH (month, day, and year): Nov. 10th 1880

7 AGE: 46 Years 11 Months 29 Days. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town): Wheeling W. Va.

(State or country)

PARENTS

10 NAME OF FATHER: George Schwartzmair

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Landauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Michael J. Nelson (Husband)

(Address) 2800 Clifton Pk. Terrace

Filed NOV 11 1927 HARRY JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Nov. 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1927, to Nov 9, 1927, that I last saw h~~e~~ alive on Nov 9, 1927, and that death occurred, on the date stated above, at 9.40 A m

The CAUSE OF DEATH* was as follows:

Ruptured appendix

(Peritonitis)

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): Toxemia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? Yes Date of 11 4 27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Lawrence Fahrney, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial: Nov 12th 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27335 ✓ 43 E 27335

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospital ST. 27-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Malone

(a) RESIDENCE NO. 112 Belmont ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs mos ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Malone

6 DATE OF BIRTH (month, day, and year) July 24th 1857

7 AGE	Years	Months	Days 14	If LESS than 1 day, hrs or min.
	70	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Owen Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Clinhamm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Marie B. Wilson (Daughter)
(Address) 110 Belmont Road

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8- 1927

17 I HEREBY CERTIFY, That I attended deceased from 8-6- 1927 to 11-8 1927

that I last saw him alive on 11-8- 1927

and that death occurred, on the date stated above, at 5:45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Floor of Mouth and Tongue

(duration) yrs mos ds

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Nov 11th 1927

20 UNDERTAKER Lilly + Zeiler

ADDRESS 4038 Woodland Ave

Spec.–7-17-26—A Co.—200 Bks.

E 27336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27336

117

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] St., [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [illegible]

(a) RESIDENCE NO. [illegible] St. [illegible] Ward

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julius R. Wirth.

6 DATE OF BIRTH (month, day, and year): Oct 12, 1875

7 AGE: Years 52 Months — Days 25 IF LESS than 1 day ..... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: [illegible] Reichel

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: [illegible] Stitt

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 [illegible]

(Address) [illegible]

Filed NOV 11 1927

[illegible] HAYDEN JONES, M. D.

Per [illegible]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 [illegible] 1927

17 I HEREBY CERTIFY, That I attended deceased from 11 [illegible], 1927 to 11 [illegible], 1927,

that I last saw h[illegible] alive on 11 [illegible], 1927,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Appendicitis, acute

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 11-3-27

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) Hayden Jones, M. D.

, 1927 (Address) 1315 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Cemetery

Date of Burial: Nov. 12th 1927

20 UNDERTAKER: Lilly + Zeller

ADDRESS 4032 Woodland

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—[illegible] Bks.

E 27337

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 27337

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 11-24 WARD)

2-FULL NAME John Wellborne

(a) RESIDENCE NO. 424 W Biddle ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 [illegible]le, Married, W[illegible]d, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Mamie Wellborne

6 DATE OF BIRTH (month, day, and year): Unknown 1885

7 AGE: Years 42; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hotel Proprieter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N.C.

PARENTS

10 NAME OF FATHER: John Willborne.

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Uknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Uknown

14 Informant: Mamie Wellborne

(Address) 424 Biddle St.

15 Filed 11 1927 19 C. HAMPSON JONES, M. D. Registrar

For [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-8-27 19 27

17

I HEREBY CERTIFY, That I attended deceased from 10-25-27, 19, to 11-8-27, 19,

that I last saw him alive on 11-8-27, 19,

and that death occurred, on the date stated above, at 10 55 P m.

The CAUSE OF DEATH* was as follows:

1 Rheumatic Cardiovascular disease. Mitral & aortic insufficiency

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Myocardial failure & Broncho pneumonia (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) E. M. Robertson M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvery Cem.

DATE OF BURIAL: Nov. 11 27

20 UNDERTAKER: Wm. R. G. Elliott

ADDRESS: 1725 Eastland Av.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 27338

E 27338
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO.

City of BALTIMORE: (No. 226 Pearl St. 4-25 Ward)

2-FULL NAME Edna Felix Dobson Broose

(a) RESIDENCE NO. 226 Pearl St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 18 1917.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Pinkney Broose

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Dobson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Phila Pa

14 Informant: Emma Dobson
(Address): 752 Cascade St.

15 Filed: OCT 11 1927 — C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds. 2 hrs.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) C. Hampson Jones M. D.

(Address) 1412 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cem — Date of Burial: 11/12 1927.

20 UNDERTAKER: Mrs Hattie R Williams — ADDRESS 822 N Schroeder St

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27339

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

186-003 E 27339

REGISTERED NO.

City of BALTIMORE: (No. St. Joseph Hospital St., 9-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. Alvin C. Long

(a) RESIDENCE NO. 1305 N. Eden St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 9 mos. 13 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28/1920

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	6	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Alvin H. Long

11 BIRTHPLACE OF FATHER (city or town)

(State or country) St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER Rosalie Goldsborough

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Alvin H. Long

(Address) 1305 N. Eden St

15 Filed NOV 11 1927 19 C. HAMPSON JONES, M. D. Registrar

Per R P H

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull- Struck by autimo (Preston St nr Eden) accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. E. Hellen M. D.

(Coroner)

11/12/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial Nov 12th 1927

UNDERTAKER George Schilling & Sons ADDRESS 1126 E Monument St

very important. See instructions on back of certificate.

OCCUPATION IS

Spec.—1-10-21—M&T—1500 Bks.

Dodge.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27340

CERTIFICATE OF DEATH.

#4 E 27340

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square Hosp.

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. 19-27 WARD)

2-FULL NAME Mrs. Ida Dodge.

(a) RESIDENCE NO. Laurel, Md. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female.

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory hand.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs. Eleanora Klegmaier

(Address) 1312 E. North Ave.

15 Filed 11 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1927, to Nov. 10, 1927; that I last saw h[illegible] alive on Nov. 10, 1927 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver.

(duration) 1 (?) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Hypertension. Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Laurel, Md.

Did an operation precede death? Yes Date of Oct 24/1927

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Elizabeth B. Sherman M. D.

19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ivy Hill Cemetery Laurel

DATE OF BURIAL: Nov 12 1927

20 UNDERTAKER: Edward N Fisher

ADDRESS: Laurel Md

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27341

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27341

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hosp. ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Snead

(a) RESIDENCE NO. Reno Va ST., WARD Reno Va

(Usual place of abode)

Length of residence in city or town where death occurred yrs 1 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wh	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Snead

6 DATE OF BIRTH (month, day, and year) April 25 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	60	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot

(b) General nature of industry, business, or establishment in which employed (or employer) Steam Ship

(c) Name of employer U S Northumberland

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER William Snead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ann Harding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) U S Marine Hospital 21st & Pennsylvania Ave

15 Filed 11-1927, 19 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 19, 1927, to Nov 10, 1927, that I last saw him alive on Nov 10, 1927 and that death occurred, on the date stated above, at 8 45 p m

The CAUSE OF DEATH* was as follows:

Hemorrhage Cerebral

Burns Multiple 2° & 3° Degree

& Larnx

(duration) yrs 1 mos 10 ds

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs 1 mos. 25 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dalton Hartley M. D.

(Address) U S Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reno Va DATE OF BURIAL Nov 10 1927

UNDERTAKER Harry H. Woltz & Co ADDRESS 153 W. Lombard St.

THIS IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—8-9-19—H. P. Co.—1000 Bks.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27342

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

129 E 27342

REGISTERED NO.

CITY OF BALTIMORE: No. 132 E. Hamilton ST. 27-43 WARD.

2-FULL NAME Katherine Reitemeyer

(a) RESIDENCE. No. 132 E. Hamilton ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm H. Reitemeyer

6 DATE OF BIRTH (month, day, and year) Sept 1/68

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cecil

PARENTS

10 NAME OF FATHER Frank Bangs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Katherine Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wm H. Reitemeyer

(Address) 132 E. Hamilton ave

15 Filed NOV 11 1922 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Nov 9, 1927.

That I last saw h alive on , 19 .

and that death occurred, on the date stated above, at 1.40 p m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Suspected

(Signed) Dennis Lang M. D.

(Address) 33½ Hartsdale Rd Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 11/12

20 UNDERTAKER: Philip Henrig

ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27343 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27343

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Union Avenue ST. 1719 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret G. Mahaffey

(a) RESIDENCE No. 14 E. Lanvale St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 1, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER James B. Mahaffey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret A. Dinsmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa.

14 Informant Miss Harriet V. Mahaffey (Address) 14 E. Lanvale Street

15 2 1927 19 C. HARRISON JONES, M. D. Registrar

Via Penn. Railroad Escort - Miss Harriet V. Mahaffey

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10th 19 27

17

I HEREBY CERTIFY, That I attended deceased from Sept 14th, 19 27, to Nov 10th, 19 27, that I last saw her alive on Nov 9th, 19 27, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis. Edema

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical findings

(Signed) I. J. A. Fiske, M. D.

19 (Address) 3615 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia, Pa.	11/12 19 27

20 UNDERTAKER Henry U. Mears & Son

ADDRESS Baltimore, Md.

Spec.—1-12-23—M&T—500 lbs.

E 27344

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27344

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3037 N. North Ave (ST.) 15-67 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen A Linker

(a) RESIDENCE NO. 3037 N. North Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 30, 1911

7 AGE — Years: 16 — Months: 6 — Days: 20 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Fred Linker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Ott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Fred Linker
(Address) 3037 N. North Ave

15 Filed DEC 1 2 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept-27, 1927, to Nov-10, 1927.

that I last saw her alive on Nov-10- 1927

and that death occurred, on the date stated above, at 3:15 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis and Parenchematous Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Personal observation

(Signed) Jno Conrad Bode, M. D.

19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: 11/12 19 27

20 UNDERTAKER: H. Cook

ADDRESS: 500 N. Howard

Spec.—1-12-23—M&T—500 Bks.

CERTIFICATE CORRECTED 3-11-59

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27345

CERTIFICATE OF DEATH.

23 E 27345

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. [redacted] St. 96 37 WARD)

BALTIMORE CITY HOSPITALS

2-FULL NAME James Julian Vincenzo Giuliani

(a) RESIDENCE No. 237 Baltimore Ave. Anondale

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Raffaela Curtis Raphell Julian

6 DATE OF BIRTH (month, day, and year): Nov 25 1892

7 AGE: Years 35 Months Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 040

(b) General nature of industry, business, or establishment in which employed (or employer): Steel Mill

(c) Name of employer: Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Domenico Giuliani

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Concetta DeLulio

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Recondo.

15 Filed 12 1927 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11 / 7 / 1927.

17

I HEREBY CERTIFY, That I attended deceased from Sept. 22. 1927. to Nov. 7. 1927.

that I last saw him alive on Nov. 7. 1927

and that death occurred, on the date stated above, at 2 20 P. m.

The CAUSE OF DEATH* was as follows:

Tetanus encephalitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General + Surg.

(Signed) C. Holmes Berg Jr., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov 11 1927

20 UNDERTAKER: William Carson — ADDRESS: 502 E Balto

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27346

CERTIFICATE OF DEATH.

100 601 E 27346

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1131 Spence St (ST.) 7572 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret White

(a) RESIDENCE NO. 1131 Spence St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Andrew White

6 DATE OF BIRTH (month, day, and year) June 26, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John A. Sauers,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Caroline Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Berlin, Germany.

14 Informant: Andrew White (Address) 1131 Spence St

15 Filed 12 1927, 19 C. HAMPSON JONES, M. D. Registrar. By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from August 6, 1927, to Present, 19 ., that I last saw her alive on Nov. 11, 1927, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Chondroma - Chest Wall & Lung.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 4 times

Did an operation precede death? Yes Date of last one August 1927

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Wm. A. Stauss, M. D.

11/11, 1927 (Address) 1201 Griffis Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 11/14 19 27

20 UNDERTAKER: W. M. Cook — ADDRESS: 502 E. North Ave.

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 27347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

5/ E 27347

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Knox

(a) RESIDENCE NO. 1136 N. Calhoun St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal bol

4 Color or Race:

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Roland Knox

6 DATE OF BIRTH (month, day, and year): 1907

7 AGE — Years: 20 — Months — Days — IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): va

PARENTS

10 NAME OF FATHER: Henry Parker

11 BIRTHPLACE OF FATHER (City or town)

(State or country): va

12 MAIDEN NAME OF MOTHER: Flora Finney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): va

14 Informant: Roland Knox

(Address): 1136 Calhoune st

15 Filed 12 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 9 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1927 to Nov. 9, 1927, that I last saw h[illegible] alive on Nov 9 1927, and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) unknown

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) John A. Jaines M. D.

(Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Keller va — Date of Burial: Nov 12 1927

20 UNDERTAKER: David Easton — ADDRESS 916 E Lan ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27348 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary 118-002

CITY OF BALTIMORE: (No. 106 N. Broadway ST. 17-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Louise B. McAllester

(a) RESIDENCE NO. 710 E. 22nd Street ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C. McAllester

6 DATE OF BIRTH (month, day, and year) Aug 9 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Albany (State or country) New York

PARENTS

10 NAME OF FATHER John B. Bourne

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Maria Pyzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Wm C. McAllester

(Address) 410 E. 22nd st.

15 Filed Nov 17 1927 J. HARRISON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1927, to Nov. 10, 1927, that I last saw h[illegible] alive on November 10, 1927 and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? History, Physical Exam

(Signed) J. Frank Hewitt, M. D.

Nov 17 1927 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Nov. 12 1927

20 UNDERTAKER Wm C. Black ADDRESS 927 N. Broadway

Spec.—1-12-23—M&T—500 Blks.

E 27349 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27349

CERTIFICATE OF DEATH.

109-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2480 Durham St. 7-4 WARD)

2-FULL NAME Mary Zakrzewski

(a) RESIDENCE No. 2480 Durham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 1909

7 AGE: Years 18 | Months 5 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sewing

(b) General nature of industry, business, or establishment in which employed (or employer): 69

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Frank Zakrzewski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Barcikowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Mary Zakrzewski 2480 Durham

15 Filed 12 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 10, 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1927 to Nov. 10 1927, that I last saw her alive on Nov. 10, 1927 and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas, M. D.

(Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary | DATE OF BURIAL: Nov 14 1927

20 UNDERTAKER: E. W. Ozgas | ADDRESS: 1930 Eastern

Spec.—1-12-23—M&T—500 Blks.

E 27350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/E 27350

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals (T.B.) ST. 11-31 WARD)

2-FULL NAME Samuel Carroll

(a) RESIDENCE No. 119 W. Hughes st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Maker

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Sadie Carroll

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed 12 1927 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1927, to Nov. 8, 1927, that I last saw him alive on Nov. 8, 1927, and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. E. Mendelsohn M. D.

(Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodburn	14 Nov 27

20 UNDERTAKER J. L. Brown ADDRESS 108 Monday St

Spec.–7-17-26–A Co.—200 Bks.

E 27351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-081

E 27351

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kerns

(a) RESIDENCE NO. 2818 Lanvale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 8 mos. 10 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Kerns

6 DATE OF BIRTH (month, day, and year): 2-15-1852

7 AGE: Years 75 Months 8 Days 10 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of indnstry, business, or establishment in which employed (or employer): Ret

(c) Name of employer

9 BIRTHPLACE (city or town): Balto (State or country) Md.

PARENTS

10 NAME OF FATHER: John F. Kerns

11 BIRTHPLACE OF FATHER (City or town): Md. (State or country)

12 MAIDEN NAME OF MOTHER: Mary Devine

13 BIRTHPLACE OF MOTHER (city or town): Md. (State or country)

14 Informant: Mrs. Mary E. Kerns (Address) 2818 N. Lanvale

15 DEC 1 2 1927 C. HAMPSON JONES, M. D. Registrar

Per Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 11/12/27

17 I HEREBY CERTIFY, That I attended deceased from 11-6-27, 19, to 11/12/27, 19,

that I last saw him alive on 11/12/27, 19,

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Cause of convulsions

(Premonitory)

(duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardio renal disease

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Laurence Fahrney, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: 11/14 1927

20 UNDERTAKER: Mary A. Gawthrop — ADDRESS: 2839 Payne

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27352

CERTIFICATE OF DEATH.

90 E 27352

REGISTERED NO.

1-PLACE OF DEATH Balto Md

CITY OF BALTIMORE: (No. 2524 Druid Hill ave St. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A Young

(a) RESIDENCE NO. 2524 Druid Hill Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. 11 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Mary Elizabeth Young

6 DATE OF BIRTH (month, day, and year): ~~1842~~ 1842

7 AGE: Years 85 Months 11 Days — If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED: Cook

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: James A. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Elizabeth Deane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mary Elizabeth Young (Address) 2534 Druid Hill Ave

15 Filed DEC 1 1927, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/9/1927

17 I HEREBY CERTIFY, That I attended deceased from August, 1924, to November 9th, 1927,

that I last saw him alive on November 7th, 1927,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Marasmus Senilis (senile Decay).

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Cardiac weakness

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) C. Maxwell Hinds, M. D.

11/11/27 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem DATE OF BURIAL 11/12 19 27

20 UNDERTAKER: Samuel Saturday ADDRESS 2 N Eutaw

IMPORTANT See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 27353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-901 E 27353

1-PLACE OF DEATH

City of BALTIMORE: (No. 1111 Druid Hill Ave. 11 24 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Custer

(a) RESIDENCE NO. 1111 Druid Hill Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Randolph Custer

6 DATE OF BIRTH (month, day, and year): about 1895

7 AGE: Years 32 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 0

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: John West

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Eliz. Gundy

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Randolph Custer

(Address) 1111 Druid Hill Ave.

15 Filed 12 1927 C. HAMPSON JONES, M. D. Registrar

By _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 9 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) no other history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.

(Coroner)

Nov. 10, 1927 (Address) 2572 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial Nov 14 1927

20 UNDERTAKER: Samuel Hamby ADDRESS Middle

Or Health Officer, in Baltimore City, to whom application for burial permit is made. FAILURE to comply with this law is a misdemeanor. Every item of information called for by this certificate is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 27354

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27354

CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 4-35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen France

(a) RESIDENCE NO. 625 W. Mulberry St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Wesley France

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant

(Address) Records

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1927, to Nov. 11, 1927, that I last saw h alive on Nov. 11, 1927 and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

Arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Symptoms

(Signed) Wilmer Brandt, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial 19
20 UNDERTAKER	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 27355

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27355

CERTIFICATE OF DEATH

131

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 719 Winans Way (Ward) 28-66

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claude Bingham Whitby

(a) RESIDENCE NO. 719 Winans Way St. Ward Resident

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. ? mos. ? ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 46 yrs 3 mos 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): July-12-1881

7 AGE — Years: 46 Months: 3 Days: 27

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Camps Director

(b) General nature of industry, business, or establishment in which employed (or employer): Boys Camping

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Caroline County

(State or country): Maryland

PARENTS

10 NAME OF FATHER: James S. Whitby

11 BIRTHPLACE OF FATHER (City or town): Carolina Co

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary L. Jones

13 BIRTHPLACE OF MOTHER (City or town): Elkton

(State or country): Cecil Co. Md.

14 Informant (Address): Mrs Mary L. Whitby (mother) 719 Winans Way - city.

Filed ..... 19 .....

V 12 1927

Registrar

ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 9, 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1925 to Nov. 9 1927.

that I last saw him alive on Nov. 9, 1927.

and that death occurred, on the date stated above, at 8:35 P. m.

The CAUSE OF DEATH* was as follows:

1 Heart Block (Stokes Adams Disease).

(duration) 2 yrs. 2 mos ds.

CONTRIBUTORY (Secondary): Syphilis

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted? ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? electrocardiograms.

(Signed) Norman B. Cole, M. D.

Nov. 9. 1927 (Address) 1035 No. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial: Nov 12 1927

UNDERTAKER: Stewart Mortuary Company ADDRESS: Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27356 E 27356

CERTIFICATE OF DEATH.

179

REGISTERED NO. [illegible]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1466 Woodall (St.) 24-23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Nash

(a) RESIDENCE No. 1466 Woodall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph. Nash.

6 DATE OF BIRTH (month, day, and year): June 25: 1859

7 AGE: Years 68; Months 4; Days 18 16; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Thomas Mariner.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Sarah. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Joseph Nash. (Address) 1466 Woodall St.

15 [illegible] 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21 1927 to Nov. 11 1927, that I last saw her alive on Nov. 10 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. T. Disbury, M. D.

(Address) 636 Fork Ave

Nov. 11, 1927

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M. Oliver's Son.

DATE OF BURIAL: Nov. 14 1927

20 UNDERTAKER: Chas. L. Stevens

ADDRESS: 1501 Park Ave

TION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 27357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 27357

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 409 N. Bond St St. 6-4 Ward)

2-FULL NAME John H. Brandt

(a) RESIDENCE NO. 409 N. Bond St St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Brandt

6 DATE OF BIRTH (month, day, and year) Feb 20/1844

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	83	8	20	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Police Officer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.

(State or country)

PARENTS

10 NAME OF FATHER Henry Brandt

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.

(State or country)

14 Informant Mrs. Elizabeth Brandt

(Address) 409 N. Bond St

12 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9/ 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(Giving date) ___ yrs. ___ mos. ___ ds.

(Signed) J. S. Wallis M. D.

(Coroner)

11/10/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial Nov 12 1927

20 UNDERTAKER John Wenck ADDRESS 700 Wilkens

Be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 27358

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27358

CERTIFICATE OF DEATH

1-PLACE OF DEATH Orem

City of BALTIMORE: (No. 3164 Wilkens Ave. St. 90-70 Ward) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Alice Orem

(a) RESIDENCE NO. 3164 Wilkens Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Orem

6 DATE OF BIRTH (month, day, and year) April 7, 1853

7 AGE	Years	Months	Days
	74	7	4

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co.,

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Yingling

11 BIRTHPLACE OF FATHER (City or town) Frizelberg,

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Samuel Orem

(Address) 3164 Wilkens Ave.

15 Filed 19 C. HAMPSON LOUIS, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

November 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1927 to Nov 11 1927,

that I last saw her alive on Nov 11 1927,

and that death occurred, on the date stated above, at 5.40 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical Symptoms

(Signed) W. A. Rurle, M. D.

11/12/27 (Address) 4207 Frederick Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 11/14/27 19

20 UNDERTAKER ADDRESS

tion should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27359

66 E 27359

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Lillian & Norwood Aves. St. 28-64 Ward)

2-FULL NAME David Solomon Cline, Jr.

(a) RESIDENCE NO. Lillian & Norwood Aves. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth F. Cline

6 DATE OF BIRTH (month, day, and year) May 22, 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	39	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bond Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Helsey, Stuart & Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER David S. Cline

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Edmon, Va.

12 MAIDEN NAME OF MOTHER Emma S. Kauffman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant James H. Cnion

(Address) 4806 Almeda Ave. Howard

15 Filed C. HAMPSON JONES, M. D. Registrar

12 1927 P.M.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 10, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

about

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) C. T. Kennedy M. D.

(Coroner)

Nov 11, 1927 (Address) 2572 Edmondson Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the state ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parl Woodlawn Cemetery Date of Burial 11/12/27 19

20 UNDERTAKER Frank P. Cook ADDRESS 1003 W. Baltimore

Of Deaths in Baltimore. Last Number of Occupation is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 27360

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27360

CERTIFICATE OF DEATH

REGISTERED NO. 89

1-PLACE OF DEATH

City of BALTIMORE: (No. 108 E. 25th St., 12th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. C. LeGrande Cole

(a) RESIDENCE NO. 108 E. 25th St. 12th Ward

(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. 11 mos. 12 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie R. Cole

6 DATE OF BIRTH (month, day, and year): 11, 27, 1840

7 AGE — Years: 86 Months: 11 Days: 12

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER: Wm. Hinson Cole

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Baltimore, Md. (?)

12 MAIDEN NAME OF MOTHER: Eleanore M. Hayes

13 BIRTHPLACE OF MOTHER (city or town): ?

(State or country)

14 Informant: C. L. Cole

(Address): 4809 Norwood Ave.

12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11, 1, 27 19

17 I HEREBY CERTIFY, That I attended deceased from 11, 1, 25, 19 ..... to 11, 1, 27, 19 .....

that I last saw h[illegible] alive on 11, 1, 27, 19 .....

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 321 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: GREEN MOUNT CEMETERY

Date of Burial: Nov 12 1927

20 UNDERTAKER: Henry W. Jenkins' Sons Co

ADDRESS: McCulloh & Orchard Sts

Cor.—12-9-25—A Co.—200 Blks.

E 27360

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27360

CERTIFICATE OF DEATH

REGISTERED NO. 89

1-PLACE OF DEATH

City of BALTIMORE: (No. 108 E. 25th St., 12th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. C. LeGrande Cole

(a) RESIDENCE NO. 108 E. 25th St. 12th Ward

(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. 11 mos. 12 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie R. Cole

6 DATE OF BIRTH (month, day, and year): 11, 27, 1840

7 AGE — Years: 86 Months: 11 Days: 12

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER: Wm. Hinson Cole

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Baltimore, Md. (?)

12 MAIDEN NAME OF MOTHER: Eleanore M. Hayes

13 BIRTHPLACE OF MOTHER (city or town): ?

(State or country)

14 Informant: C. L. Cole

(Address): 4809 Norwood Ave.

12 1927 C. HAMPSON JONES, M. D. Registrar

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27361

CERTIFICATE OF DEATH.

43 ~ E 27361

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew Hospital St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Herbst

(a) RESIDENCE NO. Front & Lexington St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Betty Herbst

6 DATE OF BIRTH (month, day, and year) ------1857

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Unjnown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Charles Labst (Son)

(Address) 4234 Olensbury Ave.

15 Filed 12 1927 16 Registrar

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue (Metastasis to Mediastinum)

(Autopsy at Sinai)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema of Rt Lung

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

11/27 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rum Date of Burial 11/23 1927

20 UNDERTAKER Joseph Lewis ADDRESS 1439 Eutaw St

Spec.—1-12-23—M&T—500 Bks.

E 27362 (E 27362)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSP. ST., 1-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Frankel

(a) RESIDENCE No. 23 Lionel St. Cobelshaw WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Frankel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lena Glassman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 12 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1927, to Nov. 11, 1927, that I last saw h[illegible] alive on November 11, 1927, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma Ischio Rectal Fossa (Pelvis).

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Greensboro, N.C.

Did an operation precede death? Yes. Date of 2 yrs. ago.

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

11/11, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herman Rom — DATE OF BURIAL 11/13 1927

20 UNDERTAKER Jack Louis — ADDRESS [illegible]

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27363 HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 27363

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 Market Space St. 46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Braunstein

(a) RESIDENCE No. 20 Market Space ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Samuel Braustein

6 DATE OF BIRTH (month, day, and year) -----1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Bernard Seigel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E. Balto. St.

15 Filed NOV 12 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12 - 1927

17 I HEREBY CERTIFY, That I attended deceased from 10/11, 1927, to 11/12, 1927, that I last saw her alive on 11/11, 1927, and that death occurred, on the date stated above, at 12.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis + Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine ++

(Signed) Dr. Grunbaum, M. D.

11/12, 1927 (Address) 122 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt. Carmel DATE OF BURIAL 11/13 1927

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Balto. St.

Spec.—8-24-14—M. & T.—2000 Bks.

Spec.—8-24-14—M. & T.—2000 Bks.

E 27364

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 27364

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S Smallwood St. (WARD) 17-64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Schalitzki

(Residence in Baltimore: No. 318 S Smallwood St

St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Jan (Month) 6 (Day), 1868 (Year)

7-AGE, 59 yrs. 10 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Sailor
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Schalitzki

(Address) 318 S Smallwood St

15-

Filed 12 1927, 191..

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 11 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1924, to Nov 11 1927, that I saw h-im alive on Nov 10 1927, and that death occurred, on the date stated above, at 3 4 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Interstitial Nephritis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert O Hunter M. D.

1927, (Address) 1 W Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Cathedral Cemetery DATE OF BURIAL, Nov 14, 1927

20-UNDERTAKER George L. Schwab ADDRESS 1501 Eutaw Place

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27365

CERTIFICATE OF DEATH.

161-081 E 27365

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 946 Hanlon Av 16 23 St., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Lucy Allen Nolley

(a) RESIDENCE NO. 946 Hanlon Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11/9/27

7 AGE Years — Months — Days — If LESS than 1 day, hrs. or min. 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 946 Hanlon Ave Md

PARENTS

10 NAME OF FATHER Allen Nolley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lucy Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Lucy Nolley (Address) 946 Hanlon Ave

15 Filed DEC 1 1927 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 27

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9th, 19 27, to Nov 10th, 19 27, that I last saw h— alive on Nov. 9th, 19 27, and that death occurred, on the date stated above, at 4 A.M. m. The CAUSE OF DEATH* was as follows:

(a) Premature birth

(b) 6 Months Intubation

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis M. D.

19 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Spec.—1-10-21—M&T—1500 Bks.

E 27366

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 27366

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3248 Eolgate ST., 26 WARD)

2-FULL NAME Anna F. Vorndiek.

(a) RESIDENCE No. 3248 Eolgate ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Vorndiek

6 DATE OF BIRTH (month, day, and year) July 25 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wenceslaus Siemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John H. Vorndiek
(Address) 3248 Eolgate

15 Filed 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 7 1927 to Nov 11 1927, that I last saw h[illegible] alive on Nov 11 1927 and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism (2 hours).
arterial Hypertension + sclerosis.
Chr. nephritis — aortic + mitral insufficiency.

(duration) 1 yrs. (2?) mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy. exam + Urine.

(Signed) Louis F. Krumrine, M. D.

(Address) 722 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery DATE OF BURIAL Nov 15 1927

20 UNDERTAKER Lilly Gier ADDRESS 40 [illegible]

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 27367

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospital, 1-1 WARD)

2-FULL NAME John L. Bauer

(a) RESIDENCE No. 1005 S. Linwood ST., 1 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frances Miller Bauer

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	26.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore -

PARENTS

10 NAME OF FATHER John L. Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Frances Miller Bauer

(Address) 1005 S. Linwood Ave

15 Filed 2 1927 - 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1927

17

I HEREBY CERTIFY, That I attended deceased from 8-30- .1927. to 11-11- .1927.

that I last saw him alive on 11-11- .1927

and that death occurred, on the date stated above, at 11 57 a m.

The CAUSE OF DEATH* was as follows:

Empyema, Left. (Tuberculous in Origin) - Septicemia - (Staphylococcus.)

(duration) yrs 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Not at this time for tuberculosis

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Findings

(Signed) Balto City Hospitals M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Nov 14 1927

20 UNDERTAKER Lilly & Sons

ADDRESS 10 E Mosher St

Spec.–7-17-26—A Co.—200 Bks.

E 27368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 27368

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2941 Fait Ave St., 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Hasel

(a) RESIDENCE NO. 2941 Fait Ave St. 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: William S. Hasel

6 DATE OF BIRTH (month, day, and year): Dec 9. 1870

7 AGE — Years: 56 — Months: 11 — Days: 2

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Glenrow

(State or country): Scotland

PARENTS

10 NAME OF FATHER: Robert Fairley

11 BIRTHPLACE OF FATHER (City or town): Scotland

(State or country)

12 MAIDEN NAME OF MOTHER: Martha Millholand

13 BIRTHPLACE OF MOTHER (city or town): Scotland

(State or country)

14 Informant: Mrs. Marg. M. Hasler (daughter)

(Address)

15 Filed 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Nov. 10, 27

17 I HEREBY CERTIFY, That I attended deceased from April, 19 27, to Nov 10, 19 27, that I last saw h[illegible] alive on Nov. 10, 19 27, and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Chr. Myocarditis

Arteriosclerosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Joseph Fourtel M. D.

. 19 (Address) 8005 Ellerslie Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Nov 14 1927

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 27369

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27369

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3207 Hudson ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Bond Jr.

(a) RESIDENCE No. 3207 Hudson ST. 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Frances Bond

6 DATE OF BIRTH (month, day, and year): Sept. 15th 1866

7 AGE: Years 61 Months 1 Days 27

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Retired

(a) Trade, profession or particular kind of work: Smelter at [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer): Copper Works

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Samuel Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Louisa Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frances Bond (wife)

(Address): 3207 Hudson St

15 [illegible] 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 11th 1927

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to Nov 10, 1927,

that I last saw he alive on Nov 9, 1927,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary): acute Congestion of Both Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Place of work

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. L. Rawlins, M. D.

12 1927 (Address) 3207 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: Nov. 15 1927

20 UNDERTAKER: Lilly & Sons

ADDRESS: 400 N. Howard

IMPORTANT See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27370

REGISTERED NO. 90 E 27370

1-PLACE OF DEATH

City of BALTIMORE: (No. 2227 Linden Ave. W. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Sondheim

(a) RESIDENCE NO. 2227 Linden Ave. W. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Sondheim

6 DATE OF BIRTH (month, day, and year) Jany. 13, 1855.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	72	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Oppenheimer,

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Hannah Thanhauser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Miss. L. Sondheim

(Address) 2227 Linden Ave.

15 Filed 12 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9, 1927

17 I HEREBY CERTIFY, That I attended deceased from November 4 1927 to November 9 1927, that I last saw h.. alive on November 9 1927, and that death occurred, on the date stated above, at 11.50 P.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis Mitral Insufficiency

Aortic Stenosis Angina pectoris

8 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis Coronary Artery

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles Hirschman, M. D.

1909 (Address) 1417 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Hebrew Friendship Cem.	11/13/ 1927

20 UNDERTAKER David Sondheim ADDRESS 18-20 Wurst Pratt Ave.

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 27371

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27371

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 616 Collette St. 15-21 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth DeCorsey

(a) RESIDENCE NO. 616 Collette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Moses DeCorsey

6 DATE OF BIRTH (month, day, and year): Aug. 1867

7 AGE: Years 60 Months 3 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: George Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Maria Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Clara Brown, Daughter.

(Address)

15 Filed 12 1927 .19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-10-1927

17

I HEREBY CERTIFY, That I attended deceased from 11-6-.1927. to 11-10-.1927.

that I last saw her alive on 11-10-.1927.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) George C. Page, M. D.

.19 (Address) 1516 N. Fremont St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov 14th 1927

20 UNDERTAKER: Dennis E. Wright

ADDRESS: 1364 Mary

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 27372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 27372

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 S. Decker ave. | 1 | WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances R. Joy.

(a) RESIDENCE NO. 818 S Decker ST., 1 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Everett J Joy

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Everett J. Joy (Husband)
(Address) 818 S. Decker Ave

Filed DEC 12 1927 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 to 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1927, to Nov 9, 1927.

that I last saw h[illegible] alive on " " , 1927

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (secondary) Chronic Myocarditis

(duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alm B Lumpe, M. D.

11/11, 1927 (Address) 718 N Pat Pk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Nov. 12 1927

20 UNDERTAKER Lilly

ADDRESS 40 Wash Ave

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27373 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27373

CERTIFICATE OF DEATH

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hosp (WARD) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hope Micklon

(a) RESIDENCE NO. 220 S. 5TH ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 13-1927

7 AGE: Years — Months: 5 — Days: 28 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Mike Micklon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Katherine Teotard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Katherine Micklon

(Address): 220 S Fifth St

15 2 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 11 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 10 1927 to Nov 11 1927 that I last saw her alive on Nov 11 1927 and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Gastro enteritis (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clin. Exam.

What test confirmed diagnosis?

(Signed): Louis T. Lavy M. D.

11/11 1927 (Address) W. Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Nov. 18 1927

20 UNDERTAKER: George W. Zirkler — ADDRESS: 1737 E. Eager st.

Spec.—1-12-23—M&T—500 Blks.

E 27374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27374

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3907 Fernwood ave ST. 26-37 WARD

2-FULL NAME Charles Kimpel

(a) RESIDENCE NO. 3907 Fernwood Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Casper Kimpel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Meun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Maggie Willner

(Address) 3907 Fernwood ave

15 Filed 12 1927, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 1st, 19 27, to Nov 10th, 19 27, that I last saw him alive on Nov 9th, 19 27, and that death occurred, on the date stated above, at 1.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. 15 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Carl F. Peters, M. D.

19 (Address) 100 S. Potters Pastore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mathews Cem.

DATE OF BURIAL Nov. 13 1927

20 UNDERTAKER George W. Zirkler

ADDRESS 1797 E. Eager st.

Spec.—1-12-23—M&T—500 Bks.

E 27375

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27375

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3414 Leaverton ave ST. 21-V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice J. Parsons

(a) RESIDENCE NO. 3414 Leaverton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward G.

6 DATE OF BIRTH (month, day, and year) May 21 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Va.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Rosa L. Beck

(Address) 3414 Leaverton ave

12 1927, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1927

17 I HEREBY CERTIFY, That I attended deceased from May 10 - 1927, to Nov. 10 1927,

that I last saw h[illegible] alive on Nov. 10 1927

and that death occurred, on the date stated above, at 10-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) Allen C Bertram, M. D.

11-11, 1927 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Nov 14 1927

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager st

Spec.—1-12-23—M&T—500 Blks.

E 27376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 E 27376

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. South Balto Hosp. WARD) 23-32

2-FULL NAME John Henry Balla

(a) RESIDENCE No. 1537 Hanover ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 9 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-3-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	43	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Ohio

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John T. Balla.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary F. Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. John T. Balla.

(Address) 1537 Hanover

15 DEC 1 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1927, to Nov 11, 1927, that I last saw him alive on Nov 11, 1927, and that death occurred, on the date stated above, at 11 A m

The CAUSE OF DEATH* was as follows:

Appendicitis & Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11-9-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. Few McCully M. D.

(Address) 1 E Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem DATE OF BURIAL 11-14-1927

20 UNDERTAKER L. Few McCully ADDRESS 130 E. Fay

Spec.—1410-21—M&T—1500 Bks.

E 27377 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27377

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2168 Woodbury ave W. 13-57 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mutter Loid Harten

(a) RESIDENCE No. 2168 Woodbury ave W., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose A Harten

6 DATE OF BIRTH (month, day, and year) Feb 22 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	29	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Embalmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John J Harten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Sarah Daughaty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Rose A Harten (Address) 251 n Payson St

15 NOV 2 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10th 1927.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6th, 1927, to Nov. 10th, 1927, that I last saw him alive on Nov. 10th, 1927 and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Several mos

CONTRIBUTORY (Secondary) None X

(duration) mos.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Usual — X Ray.

(Signed) A. Hoffman, M. D.

(Address) 2540 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 14 1927
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

ATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

27378 ✓ 32 E 27378

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MANUEL - THOMAS

(a) RESIDENCE NO. 15 N. Caroline St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs mos ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word)
Male	Colored	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	11 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~East~~ Baltos Md.

PARENTS

10 NAME OF FATHER NATHANIEL - THOMAS

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Mattie Collison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 13 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 11 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov - 7 , 1927 , to Nov - 11 , 1927 ,

that I last saw him alive on Nov - 11 , 1927

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. S. Bennett M. D.

11/12, 1927 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary DATE OF BURIAL 11/13/27

20 UNDERTAKER M. A. Elliott ADDRESS 1125 Eastern Ave

Spec.—1-12-23—M&T—500 Blks.

E 27379 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 27379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 N. Hallas ST., 6-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Finch

(a) RESIDENCE NO. 205 N. Hallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wm Hmans.

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto; (State or country) Md.

PARENTS

10 NAME OF FATHER Nathan Simpson

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Margaret Wing

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Carrie C. [illegible] (Address) 205 N. Hallas

NOV 13 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11 1927

17 I HEREBY CERTIFY, That I attended deceased from 11-8, 1927, to 11-11, 1927.

that I last saw her alive on 11-11, 1927

and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia Lobular

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? Physical yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11-12 1927 (Address) 508 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Ashley Cemetery	Nov 13, 1927
20 UNDERTAKER	ADDRESS
C. Wm R. D. Elliott	1122 Ashland Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27380 — 12 E 27380

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2321 Ashland Ave ~~St.~~ WARD) 7-12

2-FULL NAME Clara Bartlett

(a) RESIDENCE NO. 2321 Ashland Ave. ~~St.~~ WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William F. Bartlett

6 DATE OF BIRTH (month, day, and year) Aug. 5-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	3	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William F. Bartlett (Address) 2321 Ashland Ave

15 Filed NOV 13 1927 C. HAYDON JONES, M. D. Registrar

Per Rmn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1927.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8 1927. to Nov. 11 1927.

that I last saw her alive on Nov. 11 1927

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Lucien Loeka, M. D.

, 19 (Address) 2451 N. Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL Nov. 14 1927

UNDERTAKER Geo. C. Miller & Son

ADDRESS 2354 Jefferson

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27381
1-PLACE OF DEATH

CERTIFICATE OF DEATH

6-4

38 E 27381
REGISTERED NO.

City of BALTIMORE: (No. John Hopkins Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Sudhausen

(a) RESIDENCE NO. 1928 E. Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Coal

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Clements Sudhausen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER May ------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant George F. Dorbert

(Address) Oriole Ave, Balto., Md.

15 Filed 13 1927 19 J. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10/27 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Aortic Aneurism

(History Angina Pectoris with Aneurism by Physician)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) D. H. Collins M. D.
(Coroner)

11/12/27 (Address) 508 E. Northern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs..mos..ds. In the State....yrs..mos..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial Nov 14 27

20 UNDERTAKER Jas C Mullen & Son ADDRESS 2318 Eutaw St

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Bks.

27382

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27382

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2029 Christian St. 20-69 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Zeltkauth

(a) RESIDENCE No. 2029 Christian St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Sarah Zeltkauth

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 52 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paperhanger

(b) General nature of industry, business, or establishment in which employed (or employer): 62

(c) Name of employer: 0

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Sarah Zeltkauth (Address) 2029 Christian St.

15 Filed: NOV 13 1927 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 19

17 I HEREBY CERTIFY, That I attended deceased from Oct-10-, 1927, to Nov-12-, 1927, that I last saw him alive on Nov-12-, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in Baltimore

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-ray, sputum

(Signed) Herman Siedle M. D.

11/19/27 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Rosedale

DATE OF BURIAL: 11/23 1927

20 UNDERTAKER

ADDRESS

Spec.—1-12-23—M&T—500 Blks.

Friesner

E 27383 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27383

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 S Bollington ST. 14 3 WARD)

2-FULL NAME John Friesner

(a) RESIDENCE NO. 412 S Bollington ST., ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Anna Friesner

6 DATE OF BIRTH (month, day, and year) Nov 1 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61 62		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Friesner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Madgelena Gebhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Friesner
(Address) 412 S Bollington ave

15 Filed NOV 13 1927 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1927, to Nov 12, 1927, that I last saw h[illegible] alive on Nov 11, 1927, and that death occurred, on the date stated above, at 530 m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

5 (duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 837 Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov 14 1927

20 UNDERTAKER Wendel & Diffel & Son — ADDRESS 378 Hanover

Cor.—12-9-25—A Co.—200 Bks.

E 27384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED No. E 27384

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital 7-4 St. Ward)

2-FULL NAME Mary K Gordon

(a) RESIDENCE NO. 160 E Lanvale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 3 mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: John Gordon

6 DATE OF BIRTH (month, day, and year): Aug 12 1908

7 AGE — Years: 19 Months: 3 Days: 29 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): House Wife

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Austria

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Austria

12 MAIDEN NAME OF MOTHER: Theresa Kanonka

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Austria

14 Informant (Address): John Gordon 160 E Lanvale

15 Filed NOV 13 1927 H. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Nov 11 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, Inquiry or Inquiry.) thereon and from the evidence obtained by said Inquiry and that said deceased came to her death (Inquest, Inquiry or Inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul TB

Exhaustion yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Operation) yrs. mos. 1 ds.

(Signed) M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Date of Burial: Nov 15 1927

20 UNDERTAKER: Kendall Dyffelson ADDRESS: 321 Cath

very important. See instructions on back of certificate.

Spec—12-23-21—E.P.R.S.—400 Bks.

E 27385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 E 27385

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 Mary Ave., Hamilton St. 27-45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hoffman

(a) Residence No. 17 Mary Ave., Hamilton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Hoffman

6-DATE OF BIRTH (month, day and year) Nov. 20, 1846

7-AGE.	If LESS than 1 day,
80 yrs. 11 mos. 21 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... At home

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Beyersdorf

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)... Unknown (State or Country),

14-

(Informant)... Emma Berlincke

(Address)... 17 Mary Ave.

15-
11-13-1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 11, 1927

17- I HEREBY CERTIFY, That I attended deceased from August 27, 1927 to Nov 11, 1927

that I last saw her alive on Nov 10 1927

and that death occurred, on the date stated above, at 7:45 A.m.

The CAUSE OF DEATH* was as follows:

Hypostatic-Pneumonia

(Duration) — yrs. — mos. 7 ds

CONTRIBUTORY (Secondary) Arteria Sclerosis (Senility) many years

(Duration) mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green M. D

11/12, 1927 (Address) Hamilton Baltimore Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
London Park Cemetery	Nov. 14, 1927
20-UNDERTAKER.	ADDRESS
FREDERICK IASSAHN & SON	FULLERTON

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—12-9-25—A Co.—200 Bks.

E 27386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 27386

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St. 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Goldsmith

(a) RESIDENCE NO. Old Folks Home, Sinai Hospital Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Goldsmith

6 DATE OF BIRTH (month, day, and year): Jan 2/1839

7 AGE: Years 87 | Months 10 | Days 10 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town)

(State or country): Germany

10 NAME OF FATHER: Edward Himmelreich

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14

Informant: Nathan Goldsmith

(Address) 1926 W North Ave.

Filed ... 1927 L. HARRISON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 12, 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1927, to Nov 12, 1927, that I last saw her alive on Nov. 12, 1927, and that death occurred, on the date stated above, at 4:00 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mallory Myers, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shaarei Tzedek Cemetery Date of Burial Nov 14/1927

20 UNDERTAKER: J. Ahrens Co. ADDRESS 2432 Eastern Ave

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 27387

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27387

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Eanolton St., 16th WARD)

2-FULL NAME Jas. Wm. Reed

(a) RESIDENCE NO. 1002 Eanolton St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Reid

6 DATE OF BIRTH (month, day, and year) ? 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Daniel Reid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Martha Reid

(Address) 1002 Eanolton ave

15 Filed NOV 13 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV. 10 1927

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1927, to Nov 10 1927, that I last saw him alive on Nov 9 1927, and that death occurred, on the date stated above, at 7.05 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam.

(Signed) Frank E. Wagner, M. D.

11/14, 1927 (Address) 57 E Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: 11/13/1927

20 UNDERTAKER: Mrs. Geo. H. Holland — ADDRESS: 1631 Druid Hill ave

REGISTERED NOV 13 1927 H. J. JONES, M. D. Registrar

REGISTERED NOV 13 1927

PARENTS IS very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 27388 HEALTH DEPARTMENT CITY OF BALTIMORE

66 E 27388

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3705 Old York Road St. 9-47 Ward)

2-FULL NAME Joseph H. Repp

(a) RESIDENCE NO. 3705 Old York Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa E. Repp

6 DATE OF BIRTH (month, day, and year) Aug 28/1875

7 AGE	Years	Months	Days 14	IF LESS than 1 day.....hrs. or.....min.
	52	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk Dealer

(b) General nature of indnstry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER William Repp

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine R. [illegible]

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Wife

(Address) 3705 Old York Road

Filed NOV 13 1927 THOMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/27 19[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. C. Ellis (Coroner) M. D.

11/12/27 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md

Date of Burial 11/13 1927

20 UNDERTAKER [illegible]

ADDRESS 502 E North Ave

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 27389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 27389

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Dolton ST. 13-54 WARD)

2-FULL NAME Margaret Paul.

(a) RESIDENCE No. 2102 Dolton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 11, 1845

7 AGE — Years: 82 Months: 8 Days: 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Paul

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna C. Roth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William J. Paul.

(Address) 210 [illegible] St.

15 Filed NOV 13 1927 WILSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1924 to Nov. 12 1927, that I last saw her alive on Nov. 12 1927, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Dysentaria

(duration) yrs. mos 1 2 ds.

CONTRIBUTORY (Secondary) Cancer of Pelvic & genital organ

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? and Nothing done Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical appearance Smears, Pain & Microscopical exam

(Signed) Edward E Dilcher M. D.

19 (Address) 3706 Johns Hopkins Hos

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov. 15 1927

20 UNDERTAKER: Weeks John H. assist. — ADDRESS: 801 N. Fayette St

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Dr McCleary 1609 Lanvale Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

27390

CERTIFICATE OF DEATH.

E 27390

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3901 St Paul ST. 17-44 (WARD)

2-FULL NAME Richard H Lynch

(a) RESIDENCE NO. 3901 St Paul ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie V. Lynch

6 DATE OF BIRTH (month, day, and year): Nov. 21, 1859

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
68	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John H. Lynch

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Frances Enson

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto Md

14 Informant: Jennie V. Lynch (Address) 3901 St Paul St

15 Date received: NOV 13 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 11 19 27

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 19 27 to Nov. 11, 19 27

that I last saw h— alive on Nov 11, 19 27

and that death occurred, on the date stated above, at 4.45 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Stanton Melchior, M. D.

, 19 (Address) 1609 Lanvale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: 11/14 19 27

20 UNDERTAKER: H. Cook

ADDRESS: 502 E Lanvale Ave

Spec.—12-9-25—A Co.—200 Bks.

E 27391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-002

E 27391

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 15-21 Ward)

2-FULL NAME James Didlake

(a) RESIDENCE NO. 2018 Ridgewood Ave St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Didlake

6 DATE OF BIRTH (month, day, and year): Aug 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	33	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sheet metal

(b) General nature of industry, business, or establishment in which employed (or employer): O.K.

(c) Name of employer: City

9 BIRTHPLACE (city or town): _____

(State or country): City

PARENTS

10 NAME OF FATHER: Chas. Didlake

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Ellen Hudgins.

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Va

14 Informant: James Didlake

(Address): 2018 Ridgewood Ave

15 [illegible]

13 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-12- 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-27, 1927, to 11-12, 1927, that I last saw h~~im~~ alive on 11-12, 1927, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Ulcer of Duodenum with Severe Hemorrhage

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Pleurisy with effusion Pericarditis with effusion and Bronchopneumonia

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov. 3, 1927.

Was there an autopsy? Yes - Nov. 12, 1927.

What test confirmed diagnosis? Clinical & autopsy

(Signed) W. J. Thorpe, M. D.

11-12, 1927 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial 11/15 1927

20 UNDERTAKER: [illegible] — ADDRESS 502 E. Madison

Very Important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27392

51 E 27392

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Barath

(a) RESIDENCE NO. 8550 Colonial St. Ward

(Usual place of abode)

Length of residence In city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 13. 1918

7 AGE: Years 9 Months 3 Days 29

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): New York

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Barath

11 BIRTHPLACE OF FATHER (City or town): Hungary.

(State or country)

12 MAIDEN NAME OF MOTHER: Sophia Karakes

13 BIRTHPLACE OF MOTHER (city or town): Hungary

(State or country)

14 Informant: Joseph Barath

(Address) 103 S. Schroeder St.

15 Filed NOV 13 1927 16 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 11/12/27

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1927, to Nov 12, 1927, that I last saw h[illegible] alive on 11/12/27, 19..., and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia

(duration) ... yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. Lawrence Fahrney, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — Date of Burial 11/15 1927

20 UNDERTAKER: H. Cook — ADDRESS 5028 Harford

very important. See instructions on back of c[illegible] of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 27393

27393 CE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 18 Forgistonfield St 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Williams

(a) RESIDENCE NO. 138 S. Ann St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Laura D. Williams

6 DATE OF BIRTH (month, day, and year) Jan 10 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	29	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 056

(c) Name of employer Baltimore Tool Co

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Laura D. Williams

(Address) 138 South Ann

15 Filed NOV 13 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 11/13/27

17 I HEREBY CERTIFY, That I attended deceased from 10/28/27, 19..., to 11/13/27, 19..., that I last saw him alive on 11/13/27, 19..., and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Syphilitic meningitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) cardiac degeneration

(duration) yrs. mos. 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lawrence Fahrney, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

Date of Burial 11/15 1927

20 UNDERTAKER Long Cook

ADDRESS 5212 Harford

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27394

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 27394

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 East Eager ST., 7-13 WARD)

2-FULL NAME Katie Steck

(a) RESIDENCE NO. 1603 East Eager ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
(Husband of) or) WIFE of George Steck

6 DATE OF BIRTH (month, day, and year) March 27 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Georgia McClain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant George Steck
(Address) 1603 East Eager

15 Filed NOV 13 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1927

17

I HEREBY CERTIFY, That I attended deceased from 11/9, 1927, to 11/11, 1927, that I last saw h alive on Nov 11, 1927, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo E Gill M. D.

11/13 19 (Address) 711 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Loudon Park Cemetery	Nov 14 1927
20 UNDERTAKER William Cook	ADDRESS 502 E North Ave

Spec.–7-17-26—A Co.—200 Bks.

E 27395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 27395

REGISTERED NO. _____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1227 Linden Ave St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie A. Blundon

(a) RESIDENCE NO. 1227 Linden Ave St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert M. Blundon

6 DATE OF BIRTH (month, day, and year): Apr. 2. 1848

7 AGE — Years: 79 Months: 7 Days: 9

IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Va.
(State or country)

PARENTS

10 NAME OF FATHER: Joseph Downing

11 BIRTHPLACE OF FATHER (City or town): Va.
(State or country)

12 MAIDEN NAME OF MOTHER: Caroline Blackwell

13 BIRTHPLACE OF MOTHER (city or town): Va.
(State or country)

14 Informant: Lula B. Watts
(Address) 404 Park ave

15 Filed NOV 13 1927 C. HAYSON JONES, M.D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 June 11 1927

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

that I last saw h[illegible] alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Chronic nefritis

_____ (duration) about yrs. mos. ds.

CONTRIBUTORY (Secondary) uraemia

_____ (duration) several yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? typical symptoms

(Signed) Wm A Luetscher, M. D.

. 19 (Address) 17 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: Nov 14 1927

20 UNDERTAKER: John O. Stitcher — ADDRESS: Pine St Undertaker

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27396 HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

124 E 27396

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Jackson ST. 24-34 WARD)

2-FULL NAME Henrietta C. Carroll

(a) RESIDENCE No. 1721 Jackson ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female,	White.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John R. Carroll.

6 DATE OF BIRTH (month, day, and year) Feb, 14, 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	84,	8,	28. 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Barney E Burgess.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Donaldson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14

Informant Mary Cook, (Daughter).

(Address) 1721 Jackson St.

Filed NOV 13 1927, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11, 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1927, to Nov 11, 1927, that I last saw her alive on Nov 11, 1927 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis Arterial Sclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual tests

(Signed) M. E. Lichtenberg, M. D.

11/14, 1927 (Address) 1111 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Nov 14 1927

20 UNDERTAKER C. Howard Evans ADDRESS 388 E Fayette

IMPORTANT See instructions on back of certificates.

Cor.—12-9-25—A Co.—290 Hks.

E 27397

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003 E 27397

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. 33rd & Calvert St., Ward 15-67)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret A. Franklin

(a) RESIDENCE NO. 3042 W. North ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Edwin Franklin

6 DATE OF BIRTH (month, day, and year) March 22, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	54	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER David Mobbott

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Butler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Pyne

(Address) Fredericksburg, Va.

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

NOV 13 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/10 1927

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Inquest (Inquest and/or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy and/or Inquiry.) and that said deceased came to death on the day stated above.

18 CAUSE OF DEATH* was as follows: Contusions & Lacerations Accident

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] (Coroner) M. D.

11/12 1927 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial Nov. 14, 1927

UNDERTAKER E. Leroy Stiffler ADDRESS 125 E. North ave.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

27398

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27398

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. [illegible] ST., 711 WARD)

2-FULL NAME ARNOLD - Biscoe

(a) RESIDENCE NO. 604 Linwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 29 1927 Baltimore

7 AGE: Years 10 weeks; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Biscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Sally Sauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant [illegible] HOPKINS HOSPITAL (Address)

15 Filed NOV 13 1927 T. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov- 12 1927

17 I HEREBY CERTIFY, That I attended deceased from October 3, 1927, to Nov- 12, 1927, that I last saw h[illegible] alive on November 12, 1927 and that death occurred, on the date stated above, at 5.30 A.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Gastro-enteritis and septicemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home - Baltimore

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis?

(Signed) W. C. Godwin, M. D.

Nov 12, 1927 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Nov 14 1927

20 UNDERTAKER: Gus M. Frick & Son — ADDRESS: 811 W Mad

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27399

CERTIFICATE OF DEATH.

E 27399

Registered No. C

1-PLACE OF DEATH Charles S. Maffett

City of BALTIMORE: (No. Colonial Hospital St. 27-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. CHARLES S. MAFFETT

(Residence in Baltimore: No. 424 Franklin Ave. St., yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Unknown 1 (Month) (Day) (Year)

7-AGE. About 51 yrs. mos. ds. If LESS than 1 day, hrs. or mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Saleman
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Cartersville Ga.

PARENTS

10-NAME OF FATHER. William F Maffett

11-BIRTHPLACE OF FATHER. (State or Country). Ga

12-MAIDEN NAME OF MOTHER. Laura Smith

13-BIRTHPLACE OF MOTHER. (State or Country). Ga/

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgie M. Keyser

(Address) 2911 Kate Ave. Balto. Md.

15- (Filed) NOV 13 1927 192 C. HANCOCK JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. November 10th 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. T. Hennessey M. D. (Coroner)

Nov 11 192 7 (Address) 2377 Eutaw Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. Cartersville Ga. DATE OF BURIAL. Nov. 15th 1927

20-UNDERTAKER. Harry N. Dorsey ADDRESS 1521 W. Lombard St.

NOV 13 1927

—Every item of information should be carefully supplied. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 27400 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 27400

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1543 Ridgley ST. 21-32 (WARD)

2-FULL NAME Albert E Roberts

(a) RESIDENCE NO. 1543 Ridgley ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Roberts

6 DATE OF BIRTH (month, day, and year) Aug 16 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hendlers

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Albert Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Mrs Virginia Roberts 1543 Ridgley St

15 Filed NOV 14 1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1927, to Nov 12, 1927, that I last saw h alive on Nov 11, 1927, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

11 10. 1927 (Address) 611 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL 11/14 1927

20 UNDERTAKER H C Cook — ADDRESS 502 E North Ave

Spec.—7-17-26—A Co.—200 Bks.

E 27401

Geo. McCullen Haines

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27401

REGISTERED NO.

1-PLACE OF DEATH Colonial Hospital

City of BALTIMORE: (No. Laurens & Mount St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George McC Haines

(a) RESIDENCE NO. Dundalk Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1-1864

7 AGE: Years 63 yrs. Months 2 Days 11

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Pennsylvania~~

(State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Haines

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catharine ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania.

14 Informant Mrs E F Haines

(Address) 1929 Now Pittsburg Dundalk

15 Filed NOV 14 1927 19 C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 12th 1927

17 I HEREBY CERTIFY, That I attended deceased from 7-4-27, 19, to 11-12, 1927,

that I last saw h alive on 11-12, 1927,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~Sugar~~ Blood & Urine

(Signed) Julius Bialostosky, M. D.

19 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Meadow Branch Carroll Co Md — Date of Burial 11/15 1927

20 UNDERTAKER: Mrean Cook — ADDRESS Gay & Mad

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27402

CERTIFICATE OF DEATH.

129 E 27402
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 25 S. Arlington Av ST. 18-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard F Taneyhill

(a) RESIDENCE NO. 25 S. Arlington St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mo.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband of Sadie Taneyhill

6 DATE OF BIRTH (month, day, and year): Nov 4 1856

7 AGE: Years 71 Months Days 7 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED: Mill Hand for B and O. R R

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B and O R R.

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Samuel Taneyhill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore City

12 MAIDEN NAME OF MOTHER: Annie Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Sadie Taneyhill (Address) 25 S. Arlington Ave

15 Filed NOV 14 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11, 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from 1900, 19 , to Nov 12th, 1927. that I last saw him alive on Nov 12th, 1927 and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchial Asthma & Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? From 27 yrs

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Tebault, M. D.

(Address) 711 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Nov 16 1927

20 UNDERTAKER: George J. Smith — ADDRESS: 25 ~~Custom House~~ 1532 Hollins St

INSTRUCTIONS on back of certificates. See instruction is very important.

Spec.–7-17-26—A Co.—200 Bks.

E 27403

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 27403

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Chrisman

(a) RESIDENCE NO. 805 Edmonson Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ? 1865

7 AGE — Years: 62 — Months — Days — IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: maid

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) England.

PARENTS

10 NAME OF FATHER Henry Dabbs

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Dont know

14 Informant:

(Address) Riverside

15 Filed NOV 14 1927

16 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11/1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1926 to Nov. 11, 1927

that I last saw h alive on Nov. 11, 1927

and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Sept

(Signed) C. Hamilton Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

Date of Burial: Nov 14 1927

20 UNDERTAKER: Daniel Eaton

ADDRESS 24 Da

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27404

CERTIFICATE OF DEATH

100-001

E 27404

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Henderson

(a) RESIDENCE NO. 630 Dorchester St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 9-1927

7 AGE: Years 8 Months Days 3

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: no

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City md

PARENTS

10 NAME OF FATHER: Charles Henderson

11 BIRTHPLACE OF FATHER (City or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Eva Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Eva Henderson

(Address) 630 Dorchester St

15 Filed NOV 14 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 12 19 27

17

I HEREBY CERTIFY, That I attended deceased from Nov. 10 19 27 to Nov. 12 19 27

that I last saw h alive on Nov. 11 19 27

and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Taylor M. D.

19 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — Date of Burial: Nov 14 19 27

20 UNDERTAKER: Vincent Fenton — ADDRESS 916 Pa ave

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

E 27405 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27405

CERTIFICATE OF DEATH.

REGISTERED NO. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bacto City Hospt

CITY OF BALTIMORE; (No. Bacto, Md ST. 425 WARD)

2-FULL NAME Josephine Simms

(a) RESIDENCE NO. 109 Arch St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 105 yrs. mos. ds. How long in U. S. (if of foreign birth)? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widow

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1822

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	105			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bacto City Hospt (Address) Bacto Md

15 Filed NOV 14 1927 H. A. [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12-1927

17

I HEREBY CERTIFY, That I attended deceased from 10-1-1927 to 11-12-1927, that I last saw h alive on 11-11-1927, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis w/Deterioration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Nan Gladsmith M. D.

11/12/1927 (Address) Baltimore City, Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Nov 15 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Pa ave

Spec.—1-12-23—M&T—500 Blks.

E 27406

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27406

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Baltimore City Hospitals ST. 5-8 (WARD)

2-FULL NAME Elsie Johnson

(a) RESIDENCE NO. 1014 Low st. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Julius Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Laura Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

Filed NOV 14 1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1927

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to Nov. 11, 1927, that I last saw her alive on Nov. 11, 1927 and that death occurred, on the date stated above, at 10.20 a. m.

The CAUSE OF DEATH* was as follows:

Acute mononucleosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Laryngitis,

Acute Tonsilitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) L. E. Madden M. D.

11-11 27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 11/14 1927

UNDERTAKER Byrod & Wright

ADDRESS 1218 McElderry

Spec.–7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27407

REGISTERED NO. 90 E 27407

1-PLACE OF DEATH

City of BALTIMORE: (No. 1605-Eutaw Place St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Popplein

(a) RESIDENCE NO. 1605-Eutaw Place St. Ward Resident

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 2 mos. 23 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 79 yrs. 2 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) August-20-1848

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	79	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paint Manfacturer

(b) General nature of industry, business, or establishment in which employed (or employer) Paints

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Popplein

11 BIRTHPLACE OF FATHER (City or town) Frankfurt

(State or country) Germany

12 MAIDEN NAME OF MOTHER Susanna Thomsen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Laura I. Ricketts (sister)

(Address) 1605-Eutaw Place, City

15 Filed 11-15-1927 I. HAMPSON JONES, M. D. Registrar

V 14152 Per R.P.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12-1927

17 I HEREBY CERTIFY, That I attended deceased from 11-12-27, 1924, to 11-12, 1927, that I last saw h[illegible] alive on 11-12, 1927, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis with Hypertension & Chronic Interstitial Nephritis

(duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis.

(duration) yrs. mos. hours

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. J. Swanard M. D.

11-14-1927 (Address) 1604 Linden Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Greenmount Cemetery	Nov-14-1927
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)	ADDRESS 108 W. NORTH AVE.

very important. See instructions on back of certificates.

[illegible] Property classified. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

E 27408 2

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 27408

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. 1020-A ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha M. Keefer

(a) RESIDENCE NO. 37-1 Furrow ST. WARD Hemstead Farm III

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced, (write the word)~~
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14. 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Henry Keefer

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Max

13 BIRTHPLACE OF MOTHER (city or town) Balt (State or country) Md

14 Informant Mr Henry Keefer

(Address) 37 S Fremont st

Filed Dec 14 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 19 27

17

I HEREBY CERTIFY, That I attended deceased from Nov 6 , 1927, to Nov 12 , 1927, that I last saw h alive on Nov 12 , 1927 and that death occurred, on the date stated above, at 7 20 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis
C bacterial endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood culture, spinal fluid culture & autopsy findings

(Signed) J. C Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Nov 15 1927
20 UNDERTAKER	ADDRESS
Jos Joesdens Son	217 S. Bro

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27409 CERTIFICATE OF DEATH. 57 E 27409

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 1613 Orleans St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Watts

(a) RESIDENCE NO. 1613 Orleans St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Watts

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer At home

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. P. Ines

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Harriett Mullen

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Miss Dora Watts

(Address) 1613 Orleans St

NOV 14 1927

15 Filed ..... 19..

C. HARRISON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10-27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus -

over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Cain M. D.

(Coroner)

19 11/14/27 (Address) 508 E. North av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem Date of Burial 11-14 1927

20 UNDERTAKER Jas Chas. G. Bailey ADDRESS 1401 Jefferson

Spec.–7-17-26–A Co.–200 Bks.

E 27410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 27410

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. 18-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Morgan

(a) RESIDENCE NO. 1019 Druid Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored.	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Michigan

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (City or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant

(Address) BALTIMORE CITY HOSPITALS Records.

15 Filed NOV 14 1927 C. HAWSON JONES Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11/1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1927, to Nov. 11, 1927.

that I last saw h alive on Nov. 11, 1927

and that death occurred, on the date stated above, at 2.10 A. m.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Emphysema

(Secondary)

Arteriosclerosis (duration) yrs. ? mos. ds.

18 Where was disease contracted

If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Symptoms

(Signed) C. J. Friedenwald, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Zion Cemetery	Nov 16, 1927
20 UNDERTAKER Mrs. Kate R. Williams	ADDRESS 322 N. Schroeder St

very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 27411 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27411

CERTIFICATE OF DEATH. 88

1-PLACE OF DEATH

City of BALTIMORE: (No. 1041 Lanahann St St. 18-76 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Edwards

(a) Residence No. 1041 Lanahann St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse Edwards

6-DATE OF BIRTH (month, day and year) 12/23/01

7-AGE. 25 26 yrs. 10 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laundress

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Toney Davidge

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Sidney Adams

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Balto. Md

11-

(Informant) Sidney Davidge

(Address) 1115 Sarah Ann St.

15-

NOV 14 1927 HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 11-12-27

17- I HEREBY CERTIFY, That I attended deceased from 11-4-, 1927, to 11-12, 1927, that I last saw h[illegible] alive on 11-11-, 1927, and that death occurred, on the date stated above, at [illegible] a.m. The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carbolic (verbal)

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Maceo Williams M. D.

11-14, 1927 (Address) 1530 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn Cemetery

DATE OF BURIAL. Nov 15, 1927

20-UNDERTAKER. Mrs Katie R Williams

ADDRESS 322 N Schroeder St

Spec.–7-17-26—A Co.—200 Bks.

E 27412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-092

E 27412

REGISTERED NO. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 915 N. Central Ave 10th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Dersch

(a) RESIDENCE NO. 915 N. Central Ave St. 10 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. — mos. — ds. How long in U. S. if of foreign birth? 76 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: the late George Dersch

6 DATE OF BIRTH (month, day, and year): June 10 1835

7 AGE — Years: 92 Months: 5 Days: 2

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General natore of indostry, bosiness, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) ..... (State or country) Germany

PARENTS

10 NAME OF FATHER Wm. Schlerf

11 BIRTHPLACE OF FATHER (City or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country) .....

14 Informant Wm. John G. Dersch

(Address) 915 N. Central Ave

15 Filed OCT 14 1927 19 HARRY A. COOK, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 19 26 to Nov 12, 19 27

that I last saw h[illegible] alive on Nov 12th 19 27

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Uremia

Cannot say definitely

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Harry A. Cook M. D.

Nov 14, 19 (Address) 1301 E. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — Date of Burial Nov. 15 1927

20 UNDERTAKER Henry Hoeck & Son — ADDRESS 1301 E Eager

Of course all of the property changed. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

27413

CERTIFICATE OF DEATH

155 E 27413

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen. Hosp. WARD)

REGISTERED NO. 45/65

(If death occurred in a hospital or institution, give its NAME instead of street and number.

2-FULL NAME Martha Jefferson

(a) RESIDENCE No. 3900 Norfolk Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, ~~widowed, or divorced~~
~~HUSBAND of~~
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21-1879

7 AGE Years 48 Months 3 Days 22 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Balto.

PARENTS

10 NAME OF FATHER Nicholas McCombline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Hile

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland.

14 Informant (Address) 3900 Norfolk Ave

15 Filed NOV 14 1927 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/12/27

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1927, to Nov. 12 1927, that I last saw h alive on Nov. 12, 1927 and that death occurred, on the date stated above, at 2 15 a. m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of Right femur & tibia

(duration) yrs 6 weeks.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/26/27

Was there an autopsy? no.

What test confirmed diagnosis?

I, (Signed) Louis T. Fuge M. D.

11/12, 1927 (Address) U. Balto Jr. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL 19

20 UNDERTAKER Geo W Little ADDRESS

Spec.–7-17-26–A Co.—200 Blks.

E 27414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27414

REGISTERED NO. 74

1-PLACE OF DEATH

City of BALTIMORE: (No. 2520 W Lafayette Ave St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Waltemeyer

(a) RESIDENCE NO. 2520 W Lafayette Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate R. (nee Germill)

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1842

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	84	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pa.

PARENTS

10 NAME OF FATHER Wm. Waltemeyer,

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa

14 Informant Ezra F. Waltemeyer

(Address) 2520 Lafayette Ave.

15 Filed NOV 14 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 19 27, to Nov 12, 19 27

that I last saw h alive on Nov 12, 19 27

and that death occurred, on the date stated above, at 11 20 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Freedom Pa.

Date of Burial Nov 15 19 27

20 UNDERTAKER Harry H. Weitzel

ADDRESS 1536 Lombard

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27415
1-PLACE OF DEATH

129

REGISTERED NO. E 27415

City of BALTIMORE: (No. 3236 Abell Ave. St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Evans Trott

(a) RESIDENCE NO. 3236 Abell Ave. St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. 3 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1923

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	4		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel M. Trott

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Calvert Co., Md.

12 MAIDEN NAME OF MOTHER Evelyn Evans

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Samuel M. Trott
(Address) 3236 Abell Ave.

Filed NOV 14 1927 C. HARPER JONES, M. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 19 27

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 19 27, to Nov 11, 19 27, that I last saw him alive on Nov 11, 19 27, and that death occurred, on the date stated above, at Midnight. The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ernest N Rahn, M. D.

Nov 14 1927 (Address) 3002 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Park Cemetery — Date of Burial Nov 14 19 27

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

very important. See instructions on back of certificates. Label statement of OCCUPATION is property classified.

Spec.-7-17-26—A Co.—200 Bks.

E 27416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001

E 27416

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 544 Burgundy St. 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Gardner

(a) RESIDENCE NO. 544 Burgundy St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1903

7 AGE Years 24 Months 4 Days 11

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Factory & General

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Geo Gardner

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ida Brooks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Blanche Jones

(Address) 752 N. Redwood

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11/1927

17 I HEREBY CERTIFY, That I attended deceased from 11/5/27, 19, to 11/11/27, 19.

that I last saw h alive on 11/5/27, 19.

and that death occurred, on the date stated above, at 1.40 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY Acute venous (Secondary) Bronchitis (pharyngeal) about 6 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

11/7, 19 (Address) 98 Stuart St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Ct

Date of Burial Nov. 15 19 27

20 UNDERTAKER O'Brien & Son

ADDRESS 1701 N. Monty

IMPORTANT—Information called for should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27417

CERTIFICATE OF DEATH.

90 ✓

E 27417

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 102 W. York St. 72-30 St. _____ Ward)

2-FULL NAME Jacob Porter. (C)

(a) RESIDENCE NO. 102 W. York St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ------- How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	27	-------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Georgia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Emma Conway. (C)

(Address) 102 W. York St.

15 Filed ..... 19 ..... C. HARRISON JONES, M. D.

By _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 11, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congestion of the Lungs.

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____ (duration) yrs. mos. ds.

(Signed) C. M. Reinhardt M. D.

(Coroner)

11/12 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct — Date of Burial 11/15 19 27

20 UNDERTAKER H. Brune & Son — ADDRESS 1811 Pratt

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27418

CERTIFICATE OF DEATH.

74-001

E 27418

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1450 N. Parrish St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Rice

(a) RESIDENCE NO. 1450 N. Parrish St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Rice

6 DATE OF BIRTH (month, day, and year): about 1887

7 AGE: Years 40 Months Days

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va Nov. 11, 19 27

PARENTS

10 NAME OF FATHER: Charles Thompson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Marguerite Davis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Nina Rice

(Address): 1450 N. Parrish St.

15 Filed NOV 14 1927 C. HAMPSON JONES, M. D. Registrar

Per RMP

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 10, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): no other history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy (Coroner) M. D.

(Address) 2592 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery Date of Burial: Nov. 14 1927

20 UNDERTAKER: Thomas E. Kelson ADDRESS 1303 Pennsylvania Ave

Very important. See instructions on back of certificate. BE SURE TO GIVE FULL INFORMATION IN EVERY STATEMENT. DO NOT LEAVE BLANKS. IF STATEMENT OF OCCUPATION IS

Registrar Thomas G. Nelson 1303 Eastman St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27419

CERTIFICATE OF DEATH.

87 E 27419

REGISTERED NO.

1-PLACE OF DEATH Frank E. Gibney

City of BALTIMORE: (No. 1209 N. Linwood Ave St., 8-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank E. Gibney

(a) RESIDENCE NO. 1209 N. Linwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Betty Gibney

6 DATE OF BIRTH (month, day, and year) Dec 27/1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Amusements

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Christopher S. Gibney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Emma Reycob

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant Mrs. Betty Gibney

(Address) 1209 N. Linwood Ave

15 Filed NOV 14 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pericarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Pitts M. D.

(Coroner)

11/13/27 (Address) 509 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Date of Burial Nov 16 1927

20 UNDERTAKER J. A. Rebmann & Son ADDRESS 703 Hanover St.

very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

E 27420 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27420

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 Mc Culloh ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin Reynolds

(a) RESIDENCE No. 1929 Mc Culloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24-1927

7 AGE: Years — Months 8 — Days 8 — If LESS than 1 day, hrs or min. 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Eugene Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hanson Nov 17 1927

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Surgeon E. Reynolds

(Address) 1929 Mc Culloh St.

15 Filed V 14 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3d, 1927, to Nov. 12, 1927, that I last saw him alive on Nov. 12, 1927, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs mos. 8 ds.

18 Where was disease contracted if not at place of death? St Leone

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) S B Hughes M. D.

(Address) 413 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashley Cemetery — DATE OF BURIAL: Nov. 14 1927

20 UNDERTAKER: Chas. H. Johnson — ADDRESS: 1671 Carlton St

TION is very important. See instructions on back of certificates.

Spec.—I-12-23—M&T—500 Bks.

E 27421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65-001
E 27421

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. BALTIMORE CITY HOSPITALS ST. 25-7 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Bugnazewski

(a) RESIDENCE NO. 917 Curtis Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Mary Bugnazewski

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Nicholas Bugnazewski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Polanski ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant ...
(Address) Records.

15 (Date received) NOV 14 1927 C. HARRISON WHITE, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/ 8/ 1927

17
I HEREBY CERTIFY, That I attended deceased from
Aug. 10 . 1927 to Nov. 8 . 1927
that I last saw him alive on Nov. 8 . 1927
and that death occurred, on the date stated above, at 4:15 P. m.
The CAUSE OF DEATH* was as follows:
Lymphoid Leukaemia

(duration) yrs. 5 mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted ?
if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? General + Sale
(Signed) C. Holmes Wright, M. D.
, 19 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	Nov 14 1927
20 UNDERTAKER	ADDRESS
J. Sweeney & Son	1314

FROM A very important. See instructions on back of Certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 27422

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 27422

CERTIFICATE OF DEATH

1-PLACE OF DEATH Seville Apt., Lakewood Ave & Lake Drive

REGISTERED NO. 13-59

City of BALTIMORE: (No.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Isaac Wolff

(a) RESIDENCE NO. Seville Apt., Lakewood Ave & Lake Drive St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace Wolff

6 DATE OF BIRTH (month, day, and year): May 1/1879

7 AGE: Years 48 Months 6 Days 4 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Florist Assistant

(b) General nature of industry, business, or establishment in which employed (or employer): W S

(c) Name of employer

9 BIRTHPLACE (city or town) Newport, Ky

(State or country)

PARENTS

10 NAME OF FATHER Isaac Wolff

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mont Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Grace Wolff

(Address) Seville Apt.

15 Filed NOV 14 1927 H. C. HAMPTON JONES, M.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from April, 1927, to Nov. 13, 1927.

that I last saw h[illegible] alive on Nov. 9, 1927.

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio vascular Dis

Chronic Myocarditis approx. 2 years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure approx 1

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Rollin Thoorman M. D.

. 19 (Address) 2340 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr. Sinai Cemetery — Date of Burial Nov 15 1927

20 UNDERTAKER: J. Ahrens & Co. — ADDRESS 2432 Frederick Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 250 W Woodland Ave ST.) 27-56 (WARD)

REGISTERED NO. 124 E 27423

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Dawson Kinsey

(a) RESIDENCE No. 250 W. Woodland Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs + mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Hood Kinsey

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Eli Peddicord

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Mollie Shobe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md

14 Informant Walter C Bacon (Address) 1622 Eutaw St

15 Filed 11 12 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12, 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 4th. 1927. to Nov. 12. 1927. that I last saw her alive on Nov. 12. 1927 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos + ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Those of Nephritis

(Signed) Walter C Bacon M. D.

11/12. 1927 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27424

REGISTERED NO. 101-001 E 27424

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. [redacted] ST. 3-4 WARD)

2-FULL NAME Chester S. Allen.

(a) RESIDENCE NO. 1506 Eastern Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary C Allen

6 DATE OF BIRTH (month, day, and year) July 7th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John H. Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Julia A Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Records.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11/1927.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1927, to Nov. 11, 1927 that I last saw him alive on Nov. 11, 1927, and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General + Sub.

(Signed) C. Hampson Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 14 1927
20 UNDERTAKER	ADDRESS
Liston L. Russelburgh	2620 E. Pratt

BALTIMORE CITY HOSPITALS

Spec.—1-12-23—M&T—500 Bks. Vol 715 - Vol 1889

E 27425

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27425

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1405 N. Collington Ave. WARD) 816

2-FULL NAME Pauline Steinmetz

(a) RESIDENCE No. 1405 N. Collington Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Reinhard Steinmetz

6 DATE OF BIRTH (month, day, and year): May 27, 1870

7 AGE: Years 57 | Months 5 | Days 15 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jacob Schuhall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lorekam

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Geo. W. Steinmetz

(Address) 124 Brentwood Ave.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 12 1927

17

I HEREBY CERTIFY, That I attended deceased from Sept-23, 1924, to Nov-12, 1927,

that I last saw her alive on Nov 11, 1927

and that death occurred, on the date stated above, at 10 A m

The CAUSE OF DEATH* was as follows:

Carcinoma of pelvic organs and bladder

Long Knowledge (duration) 3 yrs. 1 mos 19 ds.

CONTRIBUTORY (Secondary) Carcinoma of pelvic organs and bladder (duration) 3 yrs. 1 mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Frances A. Carpenter, M. D.

10-14 1927 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem.

DATE OF BURIAL: Nov 14 1927

20 UNDERTAKER: Wm. Pickerelle

ADDRESS: Govl Pa

Spec.—1-12-23—M&T—500 Blks.

E 27426 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27426

CERTIFICATE OF DEATH.

98

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5214 Melvin Ave ST., 27-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie M. Hunt

(a) RESIDENCE No. 5214 Melvin Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dana R. Hunt

6 DATE OF BIRTH (month, day, and year) Oct 8, 1868

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
59	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Marshall Wis.

PARENTS

10 NAME OF FATHER Wm W. Strong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Lucy A Persons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Mrs. D.R. Hunt

(Address) 5214 Melvin Ave.

15 Filed NOV 14 1927 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1927

17

I HEREBY CERTIFY, That I attended deceased from 3-3, 1926, to 11-11, 1927, that I last saw h[er] alive on 11-11, 1927, and that death occurred, on the date stated above, at 9.10 P m

The CAUSE OF DEATH* was as follows:

Cardiac Arteriosclerosis
Mitral regurgitation

(duration) 4-5? yrs. mos ds.

CONTRIBUTORY (Secondary) Expression of urine

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Thomas J Cordell M. D.

11-14, 1927 (Address) 5902 Greenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Nov 14 1927

20 UNDERTAKER Wm Thickens Sons ADDRESS North Ave

Spec.—1-12-23—M&T—500 Blks.

E 27427 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27427

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3019 Garrison Ave 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Adele Merryman

(a) RESIDENCE No. 3019 Garrison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 91 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel T. Merryman

6 DATE OF BIRTH (month, day, and year) Sept 18 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	91	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Victor Chuzet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bute Md

12 MAIDEN NAME OF MOTHER Laura Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bute Md

14 Informant Adele Merryman

(Address) 3019 Garrison Ave

15 Filed NOV 14 1927 C. HAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Nov 12, 1927, that I last saw h[illegible] alive on Nov 11 1927 and that death occurred, on the date stated above, at 9 45 a m

The CAUSE OF DEATH* was as follows:

Senility.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dementia

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John F Chase M. D.

(Address) 612 N 40th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL Nov 15 1927

(UNDERTAKER) J. Pendergast Son ADDRESS Northern

Spec.—7-17-26—A Co.—200 Bks.

E 27428

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 27428

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 702 N. Fulton Ave St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Rosalba Parks.

(a) RESIDENCE NO. 702 N. Fulton Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ✓ mos. ✓ ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~Widowed, or divorced~~ ~~HUSBAND of~~ ~~the~~ WIFE of William H. Parks.

6 DATE OF BIRTH (month, day, and year): Nov. 23- 1864

7 AGE: Years 62. Months 11 Days 21

IF LESS than 1 day ___ hrs. or ___ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Jerome B. Poist

11 BIRTHPLACE OF FATHER (City or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Annie Elizabeth Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore City Md.

14 Informant: Annie V. Brown.

(Address) 702 Fulton Ave

15 NOV 14 1927 C. HAMPSON JONES, M. D. Registrar

Per ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14 - 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch 2 1927 to Nov 14 1927 that I last saw h-er alive on Nov 12 1927 and that death occurred, on the date stated above, at 1,30a m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) ✓ yrs. 1 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes. Date of Sept 5. 27 Laubery

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) George C. Shannon M. D.

(Address) 702 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial 11/17/27

20 UNDERTAKER: Chas. M. Cook — ADDRESS 1003 W. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-26—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 27429

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 E 27429

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 4-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora Stewart

(a) RESIDENCE NO. 505 W. Lombard St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Stewart

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
Abt.	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Eugene Wadsell

(Address) 102 S. Pace St.

15 Filed C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 13, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

Nov 14 27 (Signed) G. Hampson Jones M. D.

(Coroner)

, 19 (Address) 143 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery Date of Burial 11/15/1927

20 UNDERTAKER Joseph B Cook ADDRESS 1005 W. Baltimore St

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Bks.

E 27430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27430

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 4433 St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna O'Connell

(a) RESIDENCE NO. 642 E. Fort Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: James O'Connell

6 DATE OF BIRTH (month, day, and year)

7 AGE: 63 (Years | Months | Days | If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Pat Keaney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anna Treadway

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Agnes O'Connell (Address) 642 E Fort Ave

15 Filed 1927 J. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-12-27

17

I HEREBY CERTIFY, That I attended deceased from 11-7-27 to 11-12-27

that I last saw her alive on 11-12-27 8 a.m.

and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

and Chronic Myocarditis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary): Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical findings

(Signed) Eric Schaller M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Catherines — DATE OF BURIAL: 11 14 1927

20 UNDERTAKER: J. Tobin Sons — ADDRESS: 1918 Eight

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27431 ✓ 94-001 E 27431

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 150 W. University Parkway (Street) 12-09 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Funke Baum

(a) RESIDENCE NO. 150 University Parkway ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James L. Baum

6 DATE OF BIRTH (month, day, and year) Dec 31 [illegible] - 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	63	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Peoria Illinois

PARENTS

10 NAME OF FATHER Otto Funke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Elizabeth D. Kruse (Address) 11 Locust Road Baltimore

15 Filed 11 14 1927 C. HAMPSON JONES, M. D. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1927, to Nov 14, 1927, that I last saw her alive on Nov 14, 1927 and that death occurred, on the date stated above, at 11.15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger M. D.

Nov 14, 1927 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Omaha Nebraska — DATE OF BURIAL 11/17 1927

20 UNDERTAKER Henry W Jenkins & Sons Co — ADDRESS Orchard & McCulloh

THIS IS very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 27432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 27432

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE; (No. St. Joseph Hospital St. 21-33 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Lanara

(a) RESIDENCE NO. 1049 Light St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/1/49

7 AGE — Years: 78 Months: 5 Days: 3 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Italy.

(State or country)

PARENTS

10 NAME OF FATHER Vincent Gentile

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Italy.

12 MAIDEN NAME OF MOTHER Filippa Campana

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant: Michael Lanara

(Address) 1049 Light St.

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

By ..... R.H.

14 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Nov. 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 19 27, to Nov 13, 19 27,

that I last saw h[illegible] alive on Nov 13, 19 27,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Fracture neck of femur

Senility

..... (duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Unknown

..... (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. Lawrence Fahnestock M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Cross R.R. Co	11/16 1927
20 UNDERTAKER	ADDRESS
J. J. Foley & Sons	131 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27433

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST. 16-23 WARD)

REGISTERED No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore - Reeder

(a) RESIDENCE No. 1338 Mahon ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19- 1927

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	2 months		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER John Reeder

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14
Informant
(Address) Johns Hopkins Hospital

15
Filed NOV 4 1927 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1927

17
I HEREBY CERTIFY, That I attended deceased from Oct 5 , 1927 , to Nov 11 , 1927 ,
that I last saw him alive on Nov 11 , 1927
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Prematurity

(duration) yrs. 2 mos 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

Nov 14, 1927 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL NOV 1 1927

Spec.—1-12-23—M&T—500 Blks.

E 27434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27434

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 15-21 WARD)

2-FULL NAME Burnetta Green

(a) RESIDENCE NO. 1534 N. Mount ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 5 mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Father unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	5 months		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Malinda Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL (Address) Texas

15 Filed 4 1927 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1927, to Nov 6, 1927, that I last saw her alive on Nov 6, 1927, and that death occurred, on the date stated above, at 4:49 P m.

The CAUSE OF DEATH* was as follows: Dysentery(acute) miliary tuberculosis (confirmed)

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, right

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Bloody stools, Autopsy

(Signed) J. J. Bennett, M. D.

11/9/, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL NOV 7 1927

Commissioner Health

Spec.—1-12-23—M&T—500 Bks.

E 27435 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27435

CERTIFICATE OF DEATH. 74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Cole St. ST. 19-28 WARD)

2-FULL NAME William E. Campbell

(a) RESIDENCE NO. 1717 Cole St. ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Campbell

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER William Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Bridget Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Ellen Campbell (Address) 1717 Cole St.

15 Filed 4 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1927, to Nov. 10, 1927, that I last saw him alive on Nov. 10, 1927 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 2 Yrs.
Cerebral Hemorrhage

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Coy O. Donaldson M. D.

(Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11-15 1927

20 UNDERTAKER Lee A. Tuley.

ADDRESS 1500 Fayette

Spec.—1-12-23—M&T—500 Bks.

Kinyon

E 27436

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27436

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2-FULL NAME Alonzo Kinyon

(a) RESIDENCE NO. Allentown—Pa ST. _____ WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 5 ds. How long in U. S., if of foreign birth? 5 yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Amber Kinyon

6 DATE OF BIRTH (month, day, and year) 7-12-67

7 AGE: Years 60 Months 4 Days 1 If LESS than 1 day, hrs. _____ or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer 5'30

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10 NAME OF FATHER: Alonzo Kinyon

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Camilla Gaylord

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: _____ JOHNS HOPKINS HOSPITAL

(Address)

15 [illegible] 14 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-13 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 8th, 1927, to Nov. 13, 1927.

that I last saw h[illegible] alive on Nov. 13, 1927

and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

Rupture of aneurysm of internal carotid

(duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (Secondary) Aneurysm of internal carotid (duration) 4 yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov. 9-1927

Was there an autopsy? Yes Nov 13-1927

What test confirmed diagnosis? Clinical

(Signed) I. Ridgeway Trump, M. D.

Nov 19 27 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Allentown Penna

DATE OF BURIAL: Nov 14-27

20 UNDERTAKER: Philip Henry

ADDRESS 2016 Orleans

Spec.—1-12-23—M&T—500 Blks.

E 27437

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27437

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 107 Kennedy ave ST. (WARD) 9-46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Walther.

(a) RESIDENCE No. 107 Kennedy av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie. Walther.

6 DATE OF BIRTH (month, day, and year) Jan. 1 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	37.	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph. A. Walther

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER E. Rauck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Marie Walther (Address) 107 Kennedy ave.

15 Filed 11 4 1927 C. HAMPSON JONES, M. D. Registrar

Per —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1927

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1927, to Nov 1 1927 that I last saw h[illegible] alive on Nov 2nd 27 and that death occurred, on the date stated above, at 4 10 P m

The CAUSE OF DEATH* was as follows:

Tuberculosis of throat.

(duration) 4 yrs. mos ds

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Thos Jungaton M D

11/12/27 (Address) 1402 E 25 Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemty. DATE OF BURIAL Nov 5 1927.

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave.

Spec.—1-12-23—M&T—500 Blks.

E 27438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27438

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary 1947

CITY OF BALTIMORE: (NO. 1900 ST., WARD) REGISTERED NO.

2-FULL NAME Mrs. Elizabeth Rackemperger

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 413 Hoffman Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Rackemperger

6 DATE OF BIRTH (month, day, and year): May 26 1907

7 AGE: Years 20 Months 5 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Henry Kramm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Bertha Apson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14

Informant: Henry Rackemperger

(Address): 913 N Caroline St.

Filed: F 4 1927 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 3, 1927, to Nov 13, 1927, that I last saw h[er] alive on Nov 13, 1927, and that death occurred, on the date stated above, at 12:05 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombo-phlebitis - Child birth - syphilis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hazard Jones, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemty. DATE OF BURIAL: Nov. 16 1927

20 UNDERTAKER: George J. Ruth ADDRESS: 1735 Harford Ave.

Spec.—1-10-21—M&T—1500 Blks.

E 27439

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27439

CERTIFICATE OF DEATH.

173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1162 E. North ave. 9-11 WARD)

2-FULL NAME Miss annie J. Fitzmaurice

(a) RESIDENCE NO. 1162 E. North ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3, 1852

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
75	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co., Md.

PARENTS

10 NAME OF FATHER James Fitzmaurice

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Julia Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Julia E. Fitzmaurice (Address) 1162 E. North Ave.

15 Filed 14 1927 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1927

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to Nov. 14, 1927, that I last saw her alive on Nov. 14, 1927, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

General Debility
Chronic Cholecystitis &
Cholelithiasis

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Typical Evidence

(Signed) Fred B. Sylvester, M. D.

. 19 (Address) 790 N. Stanford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: 11/16 1927

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 27440

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27440

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 716 N. Hilton St. (6-67 WARD)

2-FULL NAME Jennie Bess Barry

(a) RESIDENCE NO. 716 North Hilton St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of J. Marshall Barry

6 DATE OF BIRTH (month, day, and year) Unknown 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Bernard McCullough
(Address) 712 N. Hilton St.

15 DEC 14 1927 C. HAMPSON JONES, M. D.
Per DKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927, to 11-13, 1927

that I last saw alive on 11-12, 1927

and that death occurred, on the date stated above, at 2.45A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys-Exam.

(Signed) Edward Helms, M. D.

11-14, 1927 (Address) 107 E. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 11/15/27

20 UNDERTAKER Hebb Brannig & Son — ADDRESS 517 N. Schroeder

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27441

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 N. Smallwood ST. 15-68 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Yeatts

(a) RESIDENCE NO. 1728 N. Smallwood ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Amos Yeatts

6 DATE OF BIRTH (month, day, and year) July 5, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Anna Marion
(Address) 1728 N. Smallwood

15 Filed NOV 14 1927, 19.. C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8th, 1927, to Nov 13th, 1927, that I last saw her alive on Nov. 12th, 1927 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Old age, arterio sclerosis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Heart failure 1 hour

(duration) yrs. mos. 1 hour

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. H. Burkert, M. D.

Nov 14 1927 (Address) 1100 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Nov 16 1927

20 UNDERTAKER William Cook — ADDRESS 5 E. Mulberry

Spec.—1-12-23—M&T—500 Bks.

E 27442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Dr Klingstroyt 25 Regular 44

E 27442

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2709 Boone ST., 9-46 (WARD)

2-FULL NAME August Heisterman

(a) RESIDENCE NO. 2709 Boone ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Rose E. Heisterman

6 DATE OF BIRTH (month, day, and year) July 4 1846

7 AGE: Years 81 Months 4 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Heisterman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rose E Heisterman (Address) 2709 Boone

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Aug 25th, 1927, to Nov 13th, 1927, that I last saw h~ alive on Nov 12th, 1927 and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo Fergusson M.D. M. D.

11/14/27 (Address) 4026 25 Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Presbyterian Grave

DATE OF BURIAL 11/15 1927

20 UNDERTAKER: William Cook

ADDRESS 502 E Nor

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27443

CERTIFICATE OF DEATH.

124 V.

E 27443

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. South Balto Gen Hosp St. 34-33 Ward)

2-FULL NAME Annie M. Schillinger

(a) RESIDENCE NO. 1131 Riverside Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred About 40 yrs. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis H. Schillinger

6 DATE OF BIRTH (month, day, and year): Sept. 23, 1877

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	50	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Raab

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louis H. Schillinger

(Address) 1131 Riverside Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1927, to Nov 13, 1927, that I last saw h.. alive on Nov 13, 1927, and that death occurred, on the date stated above, at 10:10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema of Gall Bladder

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Unknown

Did an operation precede death? Yes Date of Nov 13 1927

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) William H. Chase, M. D.

, 19 (Address) South Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — Date of Burial: Nov. 16 1927

20 UNDERTAKER: Margaret L. Flynn — ADDRESS: 1407 Light St.

Very important. See instructions on back of certificates. Wrongly classified. Exact statement of OCCUPATION is

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Cor.—12-8-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27444

CERTIFICATE OF DEATH.

101-001

E 27444

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 92 S Madison St., 11-24 Ward)

2-FULL NAME Ida Crocker

(a) RESIDENCE NO. 92 S Madison St Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 Color or Race colored

5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Wright

6 DATE OF BIRTH (month, day, and year) About 1862

7 AGE Years 65 Months Days

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer General

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER John Wright

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Annie Hopkins

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Andrew J. Wilson

(Address) 1340 Parkin St

15 Nov 15 1927 C. HARRISON JONES, M. D., Registrar

Fee

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (secondary) Arteriosclerosis

(duration) 1 yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

Nov 15, 1927 (Address) 23 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

(Where was disease contracted, if not at place of death?) .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lin Cemetery — Date of Burial Nov. 15, 1927

20 UNDERTAKER Mrs Katie R. Williams — ADDRESS 322 N Schroeder St

Very important. See instructions on back of certificate. If occupation is properly classified. Exact statement of OCCUPATION is

Spec.—12-9-25—A Co.—200 Bks.

Spec.—12-9-25—A Co.—200 Blks.

E 27445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 27445

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No. ____ St., 7-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schmirmund

(a) RESIDENCE NO. 711 N. Montford Ave Balt Md. St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of Rachael Schmirmund

6 DATE OF BIRTH (month, day, and year) Jan 28/51

7 AGE: Years 76 Months 9 Days 15 If LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) ____ (State or country) Md.

PARENTS

10 NAME OF FATHER John Schmirmund

11 BIRTHPLACE OF FATHER (city or town) ____ (State or country) Ger.

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) ____ (State or country) Ger.

14 Informant Rachael Schmirmund (Address) 811 N. Montford a

15 Filed NOV 15 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13th 19 27

17 I HEREBY CERTIFY, That I attended deceased from 10-30 27, 1927, to Nov 13th, 1927, that I last saw him alive on Nov 13th, 1927, and that death occurred, on the date stated above, at 9 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

CONTRIBUTORY (Secondary) Myocarditis & Arteriosclerosis (duration) ____ yrs. ____ mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ____

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. L. Dadaglisacca M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem Date of Burial 11/16 1927

20 UNDERTAKER Philip Henry ADDRESS 2016 Orleans St.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27446

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27446
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 E. Eager ST. 10 14 WARD)

2-FULL NAME Unnamed (Mueller)

(a) RESIDENCE NO. 900 E. Eager ST. 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1927.

7 AGE	Years	Months	Days	If LESS than 1 day, 18 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert A. Mueller

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) Md.

12 MAIDEN NAME OF MOTHER Edna M. Parker

13 BIRTHPLACE OF MOTHER (city or town) Cumberland (State or country) Md

14 Informant Robert A. Mueller

(Address) 902 E. Eager St. Balto. Md.

Filed NOV 15 1927 H. H. [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1927.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1927, to Nov. 14, 1927, that I last saw h (in)alive on Nov. 13, 1927, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth — (6 mo gestation)
Accidental fall of mother

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. S. Hayden, M. D.

11/14/1927. (Address) 1216 N. Carolina st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 11/15 1927

20 UNDERTAKER Philip Hermie — ADDRESS 2016 Orleans

Spec.—1-12-23—M&T—500 Blks.

E 27447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-0 E 27447

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 W. North Ave ST., 14 WARD)

2-FULL NAME Solomon L. Grott

(a) RESIDENCE NO. 803 W North Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: Mollie Grott

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 83 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Lazer Grott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mollie Grott (Address): 803 W North Ave

15 Filed NOV 15 1927 C. HAMPSON JONES, M. D. Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1927, to Nov 14, 1927,

that I last saw h... alive on ... 19...

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis - nephritis

(duration) 10 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) myocardial insufficiency

(duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Levitan, M. D.

19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edem Southern Ave. — DATE OF BURIAL: 11/15/27

20 UNDERTAKER: Jack Levi — ADDRESS: 1432 E Baltimore

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27448

CERTIFICATE OF DEATH.

101-001

101 E 27448

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals St. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Kogut

(a) RESIDENCE NO. 2042 Fountain st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catherine Kogut

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Cargen Kogut

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Spool

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records

(Address)

15 Filed 11-14-1927 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1927, to Nov. 13, 1927, that I last saw h im alive on Nov. 13, 1927 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Total Pneumonia
Myocardial Insufficiency

3 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) L. E. Madden M. D.

(Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus DATE OF BURIAL Nov 16 1927

20 UNDERTAKER J W Gazewski ADDRESS 1930 Aisquith St.

Spec.—1-12-23—M& [illegible] Letter on file from Kopera Bayerdale Md dated 11-19-27

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27449

CERTIFICATE OF DEATH.

E 27449

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto City Hospital ST. 7-4 WARD)

2-FULL NAME Casimir Kopera

(a) RESIDENCE NO. 1607 Fleet St ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
~~45~~ 54				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Kopera

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Dora -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Record
(Address)

15 Filed NOV 15 1927 Registered

E. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31 1927 to Nov. 14 1927.

that I last saw him alive on Nov. 14 1927

and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy
Acute Urinary Retention

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bilateral Pelvic Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov. 10, 1927

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs & Symptoms

(Signed) [signature] M. D.

. 19 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Hosp	11- 21
20 UNDERTAKER	ADDRESS
J. W. Ogazewski	2980 Eastern Ave

FROM A VERY important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 27450

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 27450 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hosp. 11-15-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha L Ruth

(a) RESIDENCE NO. 1658 Warwick ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Ruth

6 DATE OF BIRTH (month, day, and year) 1/11/1876

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	51	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Edward F Leigh

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER A Lauter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Charles F Ruth

(Address) 1658 Warwick Ave

15 [illegible]

NOV 15 1927 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) old age history

(duration) yrs. mos. ds.

(Signed) C. F. Steuart M. D.

(Coroner)

Nov 14, 1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Date of Burial 11/17 1927

20 UNDERTAKER George J Ruth ADDRESS 1735 Harford ave

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Cor.—12-9-25—A Co.—200 Bks.

E 27451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 27451 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No 1710 Riggs Ave St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James D. Turner

(a) RESIDENCE NO 1710 Riggs Ave, St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

10 NAME OF FATHER Perry Turner

11 BIRTHPLACE OF FATHER (city or town) Balto md

(State or country)

12 MAIDEN NAME OF MOTHER Margarite Briscoe

13 BIRTHPLACE OF MOTHER (city or town) Balto md.

(State or country)

PARENTS

14 Informant Perry Turner

(Address) 1710 Riggs av

15 Ed... C. HAMPSON JONES, M. D.

Registrar

NOV 15 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov. 12, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said I (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no other history

(Operation) yrs. mos. ds.

(Signed) J. T. Hennessey M. D.

(Coroner)

Nov. 14, 1927 (Address) 2572 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery Date of Burial Nov, 15 1927

20 UNDERTAKER Thomas E Kelson ADDRESS 1303 Pleasant St

Or. of Deaths in plain terms, so that it may be very important. See instructions on back of certificate. Exact statement of OCCUPATION is properly classified.

Cor.—11-8-23—A Co—200 Pks.

27452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1804002

E 27452

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 231 S Dallas St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kenneth M. Miles

(a) RESIDENCE NO. 231 S Dallas St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24, 1927

7 AGE — Years: — Months: 1 — Days: 9 — IF LESS than 1 day ..... hrs. or ..... min.: 24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER George Wyatt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Mable Miles

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant: Elsie Hawkins

(Address) 251 S. Dallas St.

15 Filed NOV 15 1927

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Asphyxia in bed-clothes

DURATION: yrs. mos. ds.

CONTRIBUTORY (Secondary)

DURATION: yrs. mos. ds.

Signed: H. C. Wades M. D.

, 19 (Address) 1431 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery — Date of Burial: Nov 15 1927

20 UNDERTAKER: Edward Bryan — ADDRESS: 631 Orleans St

Spec.—1-12-23—M&T—500 Blks.

Nimmo

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27453

CERTIFICATE OF DEATH.

E 27453

1-PLACE OF DEATH Church Home Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount 17 WARD)

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Nimmo

(a) RESIDENCE NO. Homewood apts. Charles & 31st WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(if non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William R. Nimmo

6 DATE OF BIRTH (month, day, and year) Mar 9, 1850

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
77	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER David N. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Jane Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant David N. Brown (Address) Mahanoy City Pa

15 Filed NOV 15 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 9 1927, to Nov. 14 1927, that I last saw h[illegible] alive on Nov. 14 1927 and that death occurred, on the date stated above, at 3.00 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Urinary Bladder.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pyelitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) George B. Brief M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL 11/17 1927

20 UNDERTAKER Wm Cook — ADDRESS 527 E Mt. Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27454 E 27454

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2829 Elliott ST., 1-1 WARD)

2-FULL NAME William Bowers

(a) RESIDENCE NO. 2829 Elliott ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaretta Bowers.

6 DATE OF BIRTH (month, day, and year) Aug 22 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
68	2	22 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Adam Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaretta Bowers. (Address) 2829 Elliott St.

15 Filed NOV 15 1927 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Octob. 15 1926 to Novemb. 13 1927.

that I last saw him alive on Novemb. 9 1927

and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

about 7

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Abscess of left lower extremity

(duration) 2 yrs 7 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of about May 8, 1927

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Jas. A. Rothblatt, M. D.

11/13 1927 (Address) 3018 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	NOV 16 1927
20 UNDERTAKER	ADDRESS
Lilly & Zeller	405 S Wolfe St

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27455

REGISTERED NO. E 27455

1-PLACE OF DEATH

City of BALTIMORE: (No. 1438 N. Milton St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M Panzer

(a) RESIDENCE NO. 1438 N. Milton St. 8 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write this word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Jno. D. Panzer

6 DATE OF BIRTH (month, day, and year) Oct. 1st 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	58	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Sebastian Pfister

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Friedel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant John A. Panzer
(Address) 1438 N. Milton st

Filed NOV 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1927, to Nov. 13 1927, that I last saw her alive on Nov 13 1927, and that death occurred, on the date stated above, at 9:10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gall Bladder

Pancreas

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Ehrman M. D.

(Address) 7136 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Redeemer Cemetery	Nov 16 1927
20 UNDERTAKER Lilly & Zeiler	ADDRESS 443 Hollins

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 27456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 27456

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3715 Talbot Av St. 12-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Augustus Nicholas

(a) RESIDENCE NO. 3715 Talbot Av St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Victoria Nicholas

6 DATE OF BIRTH (month, day, and year): October 14/1880

7 AGE: Years 47 Months 0 Days 29 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: —

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Robert Nicholas.

11 BIRTHPLACE OF FATHER (City or town): Richmond

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Jane F. Jarrett

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country)

14 Informant: Jesse L Nicholas

(Address): 1012 Arlington Ave

Filed NOV 15 1927

C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 12 19 27

17 I HEREBY CERTIFY, That I attended deceased from Sept 3rd 19 27, to Nov 12 19 27,

that I last saw h— alive on Nov 11 19 27,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exam

(Signed) Jno Hopkins Hosp M. D.

19 27 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mon Cem. Goucher — Date of Burial 11/15/27

20 UNDERTAKER: Samuel Handley — ADDRESS 5[illegible] Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-8-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27457

CERTIFICATE OF DEATH.

18 E 27457

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hosp St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Catherine Janet Gross.

(a) RESIDENCE NO. 1223 Park Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Cau

5 Single, Married, Widowed, or Divorced. (write the word): Married

3a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1905

7 AGE: Years 22 Months — Days — IF LESS than 1 day ___hrs. or ___min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto City

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Barker

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Lucie Ehrent

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Lucie Ehrent

(Address): 1223 Park Ave

Filed NOV 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Int. Obst. Peritonitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. 12 hrs.

Nov 14/27 (Signed) G C Q Caller M. D.

(Address) 1430 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial: Nov 15 1927

20 UNDERTAKER: Hamm Carter ADDRESS 946 Park Ave

If DEATH IS DUE TO EXTERNAL CAUSES, state briefly the MEANS OF INJURY, whether ACCIDENTAL, SUICIDAL, or HOMICIDAL, and the NATURE OF INJURY. This information is very important. See instructions on back of certificate. Be sure to have all items properly classified. Exact statement of OCCUPATION is of

Spec.—1-12-23—M&T—500 Blks.

E 27458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27458
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 N. Vincent St. ST., 16-72 31 WARD)

2-FULL NAME Estella Reed Jones

(a) RESIDENCE No. 1136 N. Vincient St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	16	18x 7	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work..... Unemployed
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Charles H. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Ernestine Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14
Informant Ernestine Green
(Address) 1136 N. Vincient St.

15 FILED NOV 15 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13-'27

17
I HEREBY CERTIFY, That I attended deceased from Oct. 2nd, 19 27 to Nov. 13th, 19 1927
that I last saw her alive on Nov 13, 19 27
and that death occurred, on the date stated above, at 2:35 p.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 0 yrs. 2 mos ? ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.
(Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Nov 15 19 27

20 UNDERTAKER: David Eaton — ADDRESS: 916 Cathedral

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 27459

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 E 27459

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 434 Conway St. 27-30 Ward)

2-FULL NAME Lila McG Gray

(a) RESIDENCE NO. 434 Conway St. Ward Sumter Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

3a If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph McGray

6 DATE OF BIRTH (month, day, and year) June 7, 1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Fountain Inn S C

PARENTS

10 NAME OF FATHER Robert Gray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S C

12 MAIDEN NAME OF MOTHER Florence Hunter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S C

14 Informant Joseph McG Gray

(Address) 434 Conway St

OCT 15 1927

Filed ..... 19..... Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

Screen and from the evidence obtained by said Inquiry (Coroner, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Burns of 1st & 2nd Degrees Extensive 6 hrs

(duration) mos. ds.

CONTRIBUTORY (Secondary) Shock (duration) 6 hrs mos. ds.

Oct. 14/27 19 (Address) 143 N Stricker M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fountain Inn S C — Date of Burial Oct 15 1927

20 UNDERTAKER C. H. Brown & Son — ADDRESS 1614 Main St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27460

CERTIFICATE OF DEATH

+ 38

E 27460

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. H-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy S Snowden

(a) RESIDENCE NO. Pondale, Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of B. S. Snowden.

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant Benj. Snowden

(Address) Pondale, Md

Filed NOV 15 1927 C. HAMPSON JONES, M. D. Registrar

Per R R R

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

11-10-27

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 19 21, to Nov 10, 19 27

that I last saw h.. alive on Nov 10, 19 27

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cystic cardiac vascular disease with aortic insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) F F Lucas M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnace Brandt Nov 15 19 27 Date of Burial 19

20 UNDERTAKER J. E. Brown & Son ADDRESS Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27461

CERTIFICATE OF DEATH.

100-001

E 27461

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1154 N. Calhoun ST., 16 22 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris E. Robinson Jr

(a) RESIDENCE NO. 1154 N. Calhoun ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14-26

7 AGE Years 1 Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Morris E. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mabel O. Jennings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Bessie Jennings (Address) 1154 N. Calhoun

15 [illegible] C. HAMPSON JONES, M. D. Registrar

NOV 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14 — 1927

17

I HEREBY CERTIFY, That I attended deceased from 11-13- , 1927 , to 11-14-27 ,

that I last saw him alive on 11/13 , 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cold

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? 1154 Calhoun

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) WR Boykin , M. D.

, 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Nov 17 1927

20 UNDERTAKER Sam'l N. Chase & Son ADDRESS 1400 Walker

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27462

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 1-3 WARD)

2-FULL NAME Chester Augustyniak

(a) RESIDENCE NO. 507 S. Milton Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 25, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	0	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Augustyniak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Kaleczynska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Frank Augustyniak

(Address) 507 S. Milton Ave

15 Filed NOV 15 1927, 19 HAMPSON JONES, M. D. Registrar

By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1927, to Nov 15, 1927, that I last saw him alive on Nov. 15, 1927 and that death occurred, on the date stated above, at 5 45 a.m.

The CAUSE OF DEATH* was as follows:

Pertussis (duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G Tull, M. D.

11/15, 1927 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Nov. 16 1927.
20 UNDERTAKER	ADDRESS
M J. Sadowski.	705 S. Gum St

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27463

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 82 Darby ST. 13-51 WARD) 161-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Ott

(a) RESIDENCE NO. 82 Darby ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) November 7 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ✓ min.
✓		✓	1 day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ✓ ND

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER George Simpson Ott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Hester Marie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sterling Colorado

14 Informant (Address) Father of Child

15 5 1927 . 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 7 at 11 A.M. , 1927 , to Nov. 7 at 9 P.M. 1927 ,

that I last saw her alive on Nov. 7 at 9 P.M. , 1927 ,

and that death occurred, on the date stated above, at 1:30 A.m.

The CAUSE OF DEATH* was as follows:

(Birth Injury. Bilateral Tentorial Tears.) Intracranial hemorrhage (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Prolonged labor. - Normal delivery (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? Yes.

What test confirmed diagnosis? Brain Examination.

(Signed) M. Alexander Novey, M. D.

. 19 (Address) 1516 Madison Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL ... 19

20 UNDERTAKER — ADDRESS

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 27464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27464

1-PLACE OF DEATH

City of BALTIMORE: (No. West Baltimore General St., 16 Ward) 16-68

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina Wolfel

(a) RESIDENCE NO. 2505 W. Lafayette Ave. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of the late Anton Wolfel

6 DATE OF BIRTH (month, day, and year) Dec 11 1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer Self

9 BIRTHPLACE (city or town) .....

(State or country) Germany

PARENTS

10 NAME OF FATHER Dieterich

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Schmidt

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

14 Informant Mrs E. Wolfel

(Address) 2503 W. Lafayette

15 Filed ..... By ..... C. HAMPSON JONES, M. D. Registrar

NOV 15 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatty fracture of left leg
Cerebral concussion
Automobile accident 4 ds.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) acute dil. of heart
(duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. T. Tennessee M. D.
(Coroner)

1927 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial: 11/16/27

20 UNDERTAKER: Geo. Weber's Son ADDRESS: 2503 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 27465 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 27465

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 N. Carey St. ST. 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Brigman.

(a) RESIDENCE No. 913 N. Carey ST., WARD

(Usual place of abode). (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Brigman.

6 DATE OF BIRTH (month, day, and year) Oct. 18th 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Orleans.

PARENTS

10 NAME OF FATHER Wm. D. Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen T. Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. D. Johnson.

(Address) 913 N. Carey St

15 NOV 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12th 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 12, 1927, to Nov 12, 1927, that I last saw h[illegible] alive on Nov 10, 1927, and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) W. J. Carr, Jr. M. D.

Nov 14, 1927 (Address) 5 S. Forster

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Nov. 15 1927
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1225 Ashland Av.

NOTE IS VERY important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27466

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27466

CERTIFICATE OF DEATH.

REGISTERED NO. 27143

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sycamore. Hamilton 90

CITY OF BALTIMORE: (No. 4 Sehyamore ST.) WARD

2-FULL NAME Catherine Roessel

(a) RESIDENCE NO. 4 Sehyamore ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Roessel

6 DATE OF BIRTH (month, day, and year): Nov 27 1862 (Census) 67

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
59	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): John Roessel 4 Sehyamore

15 Filed NOV 15 1927 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 25, 1925, to Nov. 14th, 1927, that I last saw h w alive on Nov. 14th, 1927, and that death occurred, on the date stated above, at 5.a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

CONTRIBUTORY (Secondary) (duration) 2 yrs. 10 mos ... ds. Cardiac Failure

(duration) ... yrs. ... mos. 15 ds.

18 Where was disease contracted if not at place of death?...

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Robert J. Kirk M.D.

Nov. 14 1927 (Address) 3176 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Park Wood — DATE OF BURIAL: Nov 16 1927

UNDERTAKER: Wendell Offel & Son — ADDRESS: 378 ...

(Instructions on back of certificates.)

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27467

REGISTERED NO. E 27467

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 E. Biddle ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Wess

(a) RESIDENCE NO. 914 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry G. Wess

6 DATE OF BIRTH (month, day, and year) Mar. 24, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Thomas Dudley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Dorgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Dr. Bernard Wess

(Address) 914 E. Biddle St.

15 Filed NOV 15 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-27. 19

17

I HEREBY CERTIFY, That I attended deceased from Nov 11/27, 19, to Nov 14/27 19

that I last saw he alive on about 11 a.m. Nov 14. 19

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Suppurative Meningitis. ov.

(duration) 3 or 4 days yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 1 dy yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. J. Ruby, M. D.

, 19 (Address) 1639 Ruxton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/17 19 27

20 UNDERTAKER Charles B. Mears & Son

ADDRESS 805 N. Calvert St.

IMPORTANT: See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Frank Schmidt ✓ 118-002

E 27463

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27468

REGISTERED NO.

1-PLACE OF DEATH South Balto Gen. Hosp. 25-75

City of BALTIMORE: (No. ..... St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Schmidt.

(a) RESIDENCE NO. 614 Palmetto St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Schmidt

6 DATE OF BIRTH (month, day, and year): Oct 8 1865

7 AGE: Years 62 year. Months 1 Days 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Austria

(State or country)

PARENTS

10 NAME OF FATHER: Vincalaus Schmidt

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Austria

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Austria

14 Informant: Margaret Schmidt

(Address) 614 Palmetto St West Brooklyn

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

NOV 15 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

11-13-27

17

I HEREBY CERTIFY, That I attended deceased from 11-9 ....., 1927, to 11-13, 1927,

that I last saw ~~him~~ alive on 11-13, 1927,

and that death occurred, on the date stated above, at 11.30 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis following operation for intestinal obstruction

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Pulm. tuberculosis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-9-27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Hampson M. D.

, 19 (Address) So Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A & E Date of Burial 11-17 19 27

20 UNDERTAKER: C & S Hartz ADDRESS 115 E West St

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 27469

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 E West St. 24-33 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Immanuel Infant of Peter J. & Elsie Brickner

(a) RESIDENCE NO. 125 E West St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11 12 1927

7 AGE: Years — Months 8 hr Foetus — Days — IF LESS than 1 day 3 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Peter J. Brickner

11 BIRTHPLACE OF FATHER (city or town) Fort Pa

(State or country)

12 MAIDEN NAME OF MOTHER Elsie May Franklin

13 BIRTHPLACE OF MOTHER (city or town) Glenburnie Md

(State or country)

14 Informant Mrs Elsie M Brickner

(Address) 125 E West St.

15 Filed NOV 15 1927 C. HAMPSON JONES, M. D.

Per _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 14 1927

17

I HEREBY CERTIFY, That I attended deceased from 11.14 1927, to 11.14 1927

that I last saw him alive on 11.14 1927

and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Premature Delivery; Birth Trauma

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ... yrs. ... mos. 3 hrs ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. J. Huntington, M. D.

, 19 (Address) 152 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A A Co — Date of Burial 11-15 1927

20 UNDERTAKER: E P Hale — ADDRESS 115 E West St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27470

CERTIFICATE OF DEATH.

128

REGISTERED NO. E 27470

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) City Hospital St. 26-37 Ward

2-FULL NAME Charles J. Froehlich

(a) RESIDENCE NO. 829 N 3rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M.

6 DATE OF BIRTH (month, day, and year) March 3- 1856

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	71	9 8	9 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER John Froehlich

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Pfeiffer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mimil L. Erickson

(Address) 829 S. Third St.

15 Filed 1927 HAMPSON JONES M. B. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Character and purpose of inquiry.) Inquiry Lis

Pendens person and from the evidence obtained by said (Coroner, Assistant Coroner or Medical Examiner) find that said deceased came to death (Cause of death as determined by Coroner or Medical Examiner.) on the day stated above.

The CAUSE OF DEATH* was as follows: Ac Nephritis

Edwin Faustow (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Nov 13 1927 G. C. Hades M. D.

19 (Address) 143 N 13th ray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem Date of Burial Nov 16 1927

20 UNDERTAKER George W. Zinkler ADDRESS 1737 E Eager st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27471

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27471

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 17-24 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wellum.

(a) RESIDENCE NO. 1213 Shields alley WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary E. Wellum

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Henry Wellum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Dean ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Relative.

15 Filed 11-15-1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/13/1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1927, to Nov. 13, 1927, that I last saw h[illegible]ive on Nov. 13, 1927, and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

myocarditis chronic & acute
Arteriosclerosis. Hypertension
? duration

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Symptoms

(Signed) C. Hampson Jones M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Cem.

DATE OF BURIAL 11-16-1927

20 UNDERTAKER Joseph A. Lively

ADDRESS 4191 Park Ave.

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 27472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 E 27472

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3900 Gwynn Oak St. 28-1st Ward)

2-FULL NAME Charles A. Meinl

(a) RESIDENCE NO. 3900 Gwynn Oak St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna A. Meinl

6 DATE OF BIRTH (month, day, and year) June 8, 1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer self

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Adolph Meinl

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Danner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Adolph Meinl

(Address) 3902 Gwynn Oak Ave

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 192 7

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) C. P. Hennessy M. D.

(Coroner)

Nov 15 192 7 (Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Date of Burial Nov 16 1927

20 UNDERTAKER Harry W. Ellen ADDRESS 1944 W North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 27473

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3100 Garrison ave ST. 15-61 WARD)

2-FULL NAME Margaret E. Norwood.

(a) RESIDENCE NO. 3100 Garrison Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Geo M. S. Norwood

6 DATE OF BIRTH (month, day, and year) Aug 12-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	76	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woodville Md

PARENTS

10 NAME OF FATHER John Gilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. M. B. Elliott

(Address) 3100 Garrison

15 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1927

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1927, to Present, 19

that I last saw her alive on Nov. 14, 1927

and that death occurred, on the date stated above, at 9:10 P m

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Strauss, M. D.

11/15, 1927 (Address) 1201 Griffis Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Cem Frederick Co Md	Nov. 16 1927
20 UNDERTAKER	ADDRESS
Harry W. Eblen	1444 W. North

THION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 27474 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27474

CERTIFICATE OF DEATH.

Registered No. 22-30 162

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Girl Coles

(a) Residence No. 104 N Hill St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Girl

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 11/6/27

7-AGE. yrs. mos. ds.

If LESS than 1 day, 14 hrs. or 35 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Wilkes Coles

11-BIRTHPLACE OF FATHER (city or town) (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER. Mary Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). North Carolina

14-

(Informant)

(Address)

15-

Filed NOV 15 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11/6/27

17- I HEREBY CERTIFY, That I attended deceased from 11/6, 1927 to 11/6, 1927 that I last saw h.. alive on 11/6, 1927 and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. L. Hebbitts, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ..., 19....

20-UNDERTAKER. ADDRESS

JOHNS HOPKINS HOSPITAL NOV 16 1927

Commissioner of Health

Dep. Com. of Health

8.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of OCCUPATION is very important. See should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Follow instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27475 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST.) (14-20 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Francis

(a) RESIDENCE No. 514 Robert St ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Col
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm Francis

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE: 57 Years | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS
10 NAME OF FATHER Wm. Lyles
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.
12 MAIDEN NAME OF MOTHER Donnella,
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Wife
(Address)

15 Filed NOV 15 1927 C. HAMPSON JONES, M. D. Registrar
By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1927, to Nov. 15, 1927, that I last saw h[illegible] alive on Nov. 15, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pneumonia Croupous

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs

(Signed) ..... M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant View Cem

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

TION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 27476

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27476

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4118 Alto Ave St. 28-63 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine M. Hernandez

(a) Residence No. 4118 Alto Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) ~~Married~~ Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Oct 18 1861

7-AGE, 66 yrs. 0 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). New York City

PARENTS.

10-NAME OF FATHER, Jno Hernandez

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Spain

12-MAIDEN NAME OF MOTHER Teresa Gonzalez

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Spain

14- (Informant) Edward J. Desvernine

(Address) 4118 Alto Ave

15- Filed NOV 15 1927 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 15 1927

17- I HEREBY CERTIFY, That I attended deceased from Sept 15, 1927, to Nov 14, 1927, that I last saw her alive on Nov 14, 1927, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

Febris

pneumonia (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. J. Tuskey M. D.

11/15, 1927 (Address) 1106 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Brooklyn New York — DATE OF BURIAL. Nov 17 1927

20-UNDERTAKER. Chas. S. Black — ADDRESS 142 W. Franklin

Classified. Exact statement of OCCUPATION is very important, and if any one is returned as having died of any disease peculiar to women or children, or of any contagious, infectious, epidemic or communicable disease, the question should be properly answered. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Barneis J

E 27477.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27477

1-PLACE OF DEATH Church Home & Infirmary. 26-45 - 45

CITY OF BALTIMORE: (No. N. Broadway & Fairmount 26-45 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Wilhelmina Barneis

(a) RESIDENCE No. 3107 Parkside Drive ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2-11 yrs mos ds Now long in U. S., if of foreign birth? yrs mos ds

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. F. Barneis Widow

6 DATE OF BIRTH (month, day, and year) May 15-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Foltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosina Weinstetter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis J. Barneis

(Address) 3107 Parkside Drive

Filed NOV 15 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1927

17

I HEREBY CERTIFY, That I attended deceased from 11/11/27, 19, to 11/14/27, 19, that I last saw h[illegible] alive on 11/14/27, 19, and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Concussion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/11/27

Was there an autopsy? yes.

What test confirmed diagnosis? yes.

(Signed) A. Sigurd Larsen, M. D.

(Address) Church Home - Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 17 1927

20 UNDERTAKER: Mrs Mrs J. M. Smith Sons — ADDRESS: 701 W. Fayette St

TION is very important See instructions on back of certificates. Exact statement of OCCUPA- that it may be properly classified.

Spec.—1-12-23—M&T—500 Blks.

E 27478 (207)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 27478

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 16-1 WARD)

2-FULL NAME HAROLD CANTLER

(a) RESIDENCE NO. 3307 O'Donnell ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~: Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-15-27

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
4 mos.	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER HAROLD CANTLER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Sethelle Phelps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Lionel JOHNS HOPKINS HOSPITAL

(Address)

15 Filed 15 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 15 1927

17 I HEREBY CERTIFY, That I attended deceased from October 19, 1927, to NOV-15, 1927, that I last saw h alive on November 15, 1927 and that death occurred, on the date stated above, at 4A. m.

The CAUSE OF DEATH* was as follows:

Marasmus - Malnutrition, enteritis. diarrhoea

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. R. Dewey Trimble M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion. Belair Md

DATE OF BURIAL: Nov 17 1927

20 UNDERTAKER: Mc Hugh & Sanderson (Tenth)

ADDRESS: 800 W Fayette

TION is very important See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27479

90 E 27479

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1709 Cairo St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Tripp

(a) RESIDENCE NO. 1709 Cairo St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 47 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 837
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant
(Address): [illegible] 1709 Cairo

15 Filed 19 [illegible] 1927 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 16 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 19 27, to Nov 16 19 27, that I last saw h[illegible] alive on Nov 16, 19 27, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion
Heart
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Pulm. Oedema
(duration) yrs. mos. 1 ds.

Is Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Hamilton, M. D.

, 19 (Address) 1709 Fairfax

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial Nov 16 19 27

20 UNDERTAKER: David Taylor ADDRESS 916 Gay

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27480

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 S Streeper St. ST. 1-1 WARD)

2-FULL NAME Andrew Szymanski

(a) RESIDENCE NO. 811 S Streeper St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Szymanski

6 DATE OF BIRTH (month, day, and year): Oct. 3 1862

7 AGE: Years 65 | Months | Days | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Martin Szymanski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Maryanna Kowierzycka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Josephine Szymanski

(Address): 811 S Streeper St.

15 11 15 1927 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1927, to Nov. 14, 1927,

that I last saw h alive on Nov 14, 1927

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank A. Janiszewski, M. D.

11/15, 1927 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary and Govt. DATE OF BURIAL: 1927

20 UNDERTAKER: John M. Weber ADDRESS: 1803 Bank

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27481

CERTIFICATE OF DEATH.

8 V E 27481

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Jones Falls near Stieff's

City of BALTIMORE: (No. [redacted] St., ____ Ward)

2-FULL NAME Joseph E Pomerlane

(a) RESIDENCE NO. 1824 Aliceanna St. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 26 1898

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	29	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Lineman

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Canada

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Helen Jameson

(Address) 1824 Aliceanna St.

15 NOV 5 1927 Filed C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: (Acc.) Drowning

Missing 4 days

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ____ yrs. ____ mos. ____ ds.

Signed C. Hampson Jones M. D. (Coroner)

Nov 25 1927 (Address) 143 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem Nov 16 1927 Date of Burial

20 UNDERTAKER John M Weber ADDRESS 1803 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

E 27482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 27482

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3901 Edmondson Ave) (Ward) 11

2-FULL NAME John Grebe

(8) RESIDENCE NO. 3901 Edmondson Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 28 ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 15, 1860

7 AGE: Years 67 Months 5 Days 28 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Linck Cleaning Co

9 BIRTHPLACE (city or town)

(State or country) Baden

10 NAME OF FATHER Henry Grebe

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER ~~Elizabeth Schuppert~~ ~~Elizabeth Hampshire~~

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baden

PARENTS

14 Informant Minnie Grebe

(Address) 3901 Edmondson Ave

NOV 15 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest and autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) about one yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. B. P. Norton M. D.

(Address) Curtis Bay Balto

Nov 15, 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London PK Cemetery Date of Burial 11/16/27

20 UNDERTAKER: Geo Lemmon & Son ADDRESS 525 N Lyndhurst St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 27483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27483

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1206 Asquith St. 10-14 Ward)

2-FULL NAME Sarah A. Groves

(a) RESIDENCE NO. 1206 Asquith St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. / mos. How long in U. S., if at foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Henry Groves

6 DATE OF BIRTH (month, day, and year): Nov 12/52

7 AGE: Years 75; Months; Days; IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town)

(State or country): Pa.

PARENTS

10 NAME OF FATHER: John Finny.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pa.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Pa.

14 Informant: William C. Groves

(Address): 1206 Asquith St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 13- 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 13 1927 to Nov 13 1927, that I last saw h[illegible] alive on Nov 13 1927 and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Postmortem

(Signed) A. Grant Townsend M. D.

11-13 1927 (Address) 708 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (see reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem Stewartstown Pa. Date of Burial 11/16/27 19

20 UNDERTAKER: George J. Ruth

ADDRESS 1734 Harford

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15 1927

Spec.—1-12-23—M&T—500 Bks.

E 27484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

27-002

27 E 27484

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 27-53 ST., WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Thomas C. Eichrist

(a) RESIDENCE NO. 107 St. Johns Rd - Balto ST. Sub WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~, or ~~Divorced~~: Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE: Years 65 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant JOHNS HOPKINS HOSPITAL

(Address)

15 Filed NOV 16 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1927, to Nov. 14, 1927, that I last saw h[illegible] alive on Nov-14, 1927 and that death occurred, on the date stated above, at 1.05 p m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(duration) yrs. 3(?) mos (history) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? laboratory & autopsy

(Signed) W. Lindsay Miller, M. D.

11/14/1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: DRUID RIDGE CEM

DATE OF BURIAL: Nov 16 1927

20 UNDERTAKER: Robert Brookerson

ADDRESS: Calhoun Hollins

NOV 16 1927

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27485

129

REGISTERED NO. E 27485

1-PLACE OF DEATH

City of BALTIMORE: (No. 118 S Gilmor St., 19-28 St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry F. Siemers,

(a) RESIDENCE NO. 118 S Gilmor St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Ida J. Siemers.

6 DATE OF BIRTH (month, day, and year) Aug. 11, 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER William Siemers

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Marvin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant John F. Nichols.

(Address) 118 S. Gilmor St.

15 Filed NOV 16 1927, 19 H. HAMPSON JONES, M. D. Registrar

16 Registered by ARK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13-27 19

17 I HEREBY CERTIFY, That I attended deceased from 6/26/27, 19 ..., to 11/13/27, 19 ..., that I last saw him alive on 11/13/27, 19 ..., and that death occurred, on the date stated above, at 10 20 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron. Chol. Nephritis ?

(duration) 1 yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path

(Signed) H. H. Jones, M. D.

11/15/27, 19 (Address) 375 Stricker

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
London Park Cemetery	11/15 19 27

20 UNDERTAKER Harvey H. Ditzler

ADDRESS Nov 16 1927

Spec.—12-9-25—A Co.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27486

CERTIFICATE OF DEATH.

351

E 27486
REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No. _____ St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Florence Stockdale

(a) RESIDENCE NO. 1324 N. Chester St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 9 1895

7 AGE: Years 32 Months — Days — —

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: "

9 BIRTHPLACE (city or town): Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Stockdale not given

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Cecelia Dignan

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Miss Julia Dignan

(Address) 1324 N. Chester St.

NOV 16 1927

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15 1927

17 I HEREBY CERTIFY, That I attended deceased from 10-29, 1927, to 11-15, 1927, that I last saw her alive on 11-15, 1927, and that death occurred, on the date stated above, at 3 40 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis with Uraemia

Tuberculosis of Hip Joints Bilateral.

(duration) .....yrs. .....mos. .....ds.

CONTRIBITORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) O. O. Knapp, M. D.

11-15, 1927. (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bonnie Brae — Date of Burial: Nov. 18 1927

20 UNDERTAKER: Harris & Metzke — ADDRESS: 1531 N. Gay St.

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27487

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27487

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3912 Eastern ave ST., 96-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Bettelman

(a) RESIDENCE No. 3912 Eastern ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Rose Bettelman

6 DATE OF BIRTH (month, day, and year): March 15 1883

7 AGE: Years 44; Months 8; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Israel Bettelman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Untaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Nathan Bettelman

(Address): 3912 Eastern ave

15 Filed NOV 16 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15 19 27

17 I HEREBY CERTIFY, That I attended deceased from July 10, 19 27, to Nov 15, 19 27, that I last saw him alive on Nov 15, 19 27, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:*

Ch. myocarditis

(duration) .. yrs. 9 mos. ds.

CONTRIBUTORY (Secondary): acute Cardiac dilatation

(duration) ..yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein, M. D.

11/16, 1927 (Address) 733 Wisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Waverly

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27488

90 E 27488

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospital ST. 4-30 WARD)

2-FULL NAME Louis Cromwell

(a) RESIDENCE No. 606 W Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and [redacted]) 1881

7 AGE: Years 46 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Louis Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louise

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hattie Washington

(Address) 311 Mount St

Filed NOV 16 1927 HAMILTON JONES, M. D. Registrar

For [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-30- 1927, to 11-12 1927, that I last saw h[illegible] alive on 11-12 1927 and that death occurred, on the date stated above, at 10:10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis. Generalized arteriosclerosis, and Senile Gangrene, Both lower extremities (Primary) (duration) Unknown ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL Nov. 16 1927

UNDERTAKER: Geo. H. Soadner — ADDRESS 1027 Lund Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27489

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. E 27489

1-PLACE OF DEATH

City of BALTIMORE: (No. 601 George St. St. 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph H Tittl

(a) RESIDENCE NO. 601 Geary St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1888

7 AGE: Years 39 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Geneva

9 BIRTHPLACE (city or town): Md.

(State or country): Md.

PARENTS

10 NAME OF FATHER Enoch White

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER Annie Jones

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Annie H Tittl

(Address): 601 George St.

15 Filed: NOV 16 1927

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 13, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no other history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

1927 (Address) 2572 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial Nov 16 1927

20 UNDERTAKER: John H. Trader ADDRESS 1627 Lord Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27490
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

101-001

E 27490
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1622 Mulliken ST., 6-9 WARD)

2-FULL NAME Esther Brooks Montgomery

(a) RESIDENCE NO. 1622 Mulliken ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Wagmon Montgomery

6 DATE OF BIRTH (month, day, and year) ?, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Maryland

PARENTS
10 NAME OF FATHER ?
11 BIRTHPLACE OF FATHER (city or town) (State or country) ?
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Waymon Montgomery
(Address) 1622 Mulliken

15 Filed NOV 16 1927 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1927

17
I HEREBY CERTIFY, That I attended deceased from Oct 30 1927 to Nov 14 1927,
that I last saw h alive on Nov. 14 1927,
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH was as follows:
Lobar Pneumonia

(duration) yrs. mos 8 ds.
CONTRIBUTORY (Secondary) Acute Myocarditis
(duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical.
(Signed) W. L. Berry, M. D.
, 19 (Address) 1520 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn cemetery — DATE OF BURIAL: Nov 17 1927

20 UNDERTAKER: Edward Bryan — ADDRESS: New Orleans

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27491

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 ✓

24-33

REGISTERED No. E 27491

City of BALTIMORE: (No. 119 E. Gittings St., Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Mercer.

(a) RESIDENCE NO. 119 E. Gittings St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	White.	Widow.

5a If ~~XXXXX~~ widowed, ~~XXXXXXX~~ (or) WIFE of Thomas Mercer.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	53	--------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Maggie Graef.

(Address) 603 N. Fremont Ave.

15 Filed NOV 16 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 14, 1927.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M. Embrich M. D. (Coroner)

11/15 19 27 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial 11/17 19 27

20 UNDERTAKER J. M. Cook ADDRESS 127 E. Hoffman St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27492

CERTIFICATE OF DEATH.

47 E 27492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hospital ST. 26-2 WARD)

2-FULL NAME Nora Chapman

(a) RESIDENCE No. 102 S Clinton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Chapman

6 DATE OF BIRTH (month, day, and year) Nov 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Wm Albaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) md. (State or country)

14 Informant John H Chapman

(Address) 102 S Clinton St

Filed NOV 16 1927 J. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14 1927

17

I HEREBY CERTIFY, That I attended deceased from 11-18, 1927, to 11-14, 1927

that I last saw h[illegible] alive on 11-14, 1927

and that death occurred, on the date stated above, at 5:45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Left Breast with Metastasis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 11/17 1927

20 UNDERTAKER W M Cook

ADDRESS 607 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27493

CERTIFICATE OF DEATH.

3L 27493

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (13-54 ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Preston Rhodes

(a) RESIDENCE NO. 1113 Whitelock st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Aleck Rhodes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Marjory Burnwington

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Caroline

14 Informant Hospital Records
(Address)

15 Filed NOV 16 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 1927

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to Nov. 13, 1927,

that I last saw him alive on Nov. 13, 1927

and that death occurred, on the date stated above, at 5.50 A. m.

The CAUSE OF DEATH* was as follows:

~~Pul Tbc~~ Tuberculous meningitis

10 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pul Tbc

~~unknown~~ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autop.

(Signed) C. E. Madden M. D.

11-14-27 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon	11/16 1927
UNDERTAKER	ADDRESS
Samuel Hardy	Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec. 1-10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27494

CERTIFICATE OF DEATH.

E 27494

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 704 Ensor (Hospital) ST. 14-54 (WARD)

2-FULL NAME Mary Pate

(a) RESIDENCE NO. 2208 E McCulloh ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susan Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mayor Pate (Address) 2208 McCulloh St.

15 Filed NOV 16 1927 H. HANSON JONES, M. D. Registrar

Date .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 1927, to Nov. 12 1927, that I last saw h.. alive on Nov 12 1927, and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)* Chronic Nephritis + Carcinoma of Uterus

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Postmortem

(Signed) D. W. Reinard M. D.

11-12 1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Nov 16 1927

20 UNDERTAKER Samuel Stanley ADDRESS 708 Eutaw

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUTION—THIS IS AN IMPORTANT LEGAL DOCUMENT. KEEP IN A SAFE PLACE. DO NOT FOLD. DO NOT SOIL OR DAMAGE IN ANY WAY. IT SHOULD BE PRESERVED AS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

E 27495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X129 E 27495

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospt. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Genieve Smith

(a) RESIDENCE NO. Carrell Dr. Hollins St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ronnie L. Smith

6 DATE OF BIRTH (month, day, and year): Aug 4, 1885

7 AGE — Years: 42 Months: 3 Days: 4 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER: Joseph C.

11 BIRTHPLACE OF FATHER (City or town): Balto. Md

(State or country)

12 MAIDEN NAME OF MOTHER: Christina Kratz

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant (Address): Hospital Records

15 Filed NOV 16 1927 G. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Nov. 13, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1927, to Nov. 13, 1927, that I last saw h[illegible] alive on Nov. 13, 1927, and that death occurred, on the date stated above, at 8:40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

Chronic Nephrocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Nov 16 1927

20 UNDERTAKER: John Ulrich ADDRESS: 2008 Orleans

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27496

129 E 27496

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2029 N. Wolfe St St. 817 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Ludloff

(a) RESIDENCE NO. 2029 N. Wolfe St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Philippina Frese

6 DATE OF BIRTH (month, day, and year) Aug 24/ 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Corner Works

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Jacob Ludloff

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Caroline Kistel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto., Md.

14 Informant wife

(Address)

NOV 16 1927 HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) History of Nephritis

(duration) 2 yrs. mos. ds.

(Signed) Jos Wilkins M. D.

(Coroner)

11/15/27 (Address) 500 E. Northern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem Date of Burial Nov 17 1927

20 UNDERTAKER John Ellrich ADDRESS 2008 Orleans

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27497

CERTIFICATE OF DEATH.

167-001 E 27497

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 916 N. Chapel St St., 7-13 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel J. Tankersley

(a) RESIDENCE NO. 916 N. Chapel St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widiwer

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Tankersley

6 DATE OF BIRTH (month, day, and year) Oct 29/1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman Ud

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Tankersley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Deal's Island Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Elwood Tankersley

(Address) 916 N. Chapel St

15 Filed NOV 16 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 192 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Bren M. D.

(Coroner)

11/15/27, 19 (Address) 503 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial Nov 17 1927

20 UNDERTAKER John Weiers ADDRESS 2008 Eden

For RMK

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12 23—M&T—500 Bks.

E 27498

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO. E 27498

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 19-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Amelia Fisher

(a) RESIDENCE NO. 509 Belnord St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Maurice Fisher

6 DATE OF BIRTH (month, day, and year): Feb. 16, 1902

7 AGE — Years: 25 — Months: 8 — Days: 30 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Malovska

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Barbara Cecik

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Maurice Fisher

(Address) 509 E Belnord Ave

15 Filed NOV 16 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-15-1927

17 I HEREBY CERTIFY, That I attended deceased from 1-18-1927, 19 , to 11-15-1927, 19 .

that I last saw h[illegible] alive on 11-15-1927 19

and that death occurred, on the date stated above, at 9 52 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Glomerular Nephritis

(duration) yrs. 1 mos. 10 wks. ds.

CONTRIBUTORY (Secondary): Bronchi-Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Emil Polonsky M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — DATE OF BURIAL: Nov. 18, 1927

20 UNDERTAKER: C. Leroy Stiffler — ADDRESS: 125 E. North ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Elena E Higginbotham

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27499

CERTIFICATE OF DEATH.

E 27499

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4206 Groveland Ave. (St.) 08-63 WARD

2-FULL NAME Elena E. Higginbotham

(a) RESIDENCE No. 4206 Groveland Ave. St. Catherington WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Maurice Higginbotham

6 DATE OF BIRTH (month, day, and year) April 13, 1861

7 AGE Years 66 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Paul

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Baltimore Md

14 Informant Paul B Higginbotham

(Address) 4206 Groveland Ave.

15 Filed NOV 16 1927 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1927

17 I HEREBY CERTIFY, That I attended deceased from May 9 1927 to Nov 12 1927

that I last saw her alive on Nov 12 1927

and that death occurred, on the date stated above, at 10-30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial & Senile Affection

(duration) 6 yrs. 2 mos 8 ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo. H. Dalrymple A. M. D.

(Address) 2215 N. Howard Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Nov 16 1927

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 16 1927

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27500

CERTIFICATE OF DEATH

15 E 27500

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4357 Tuscan St. 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lorraine Teehner

(a) RESIDENCE NO. 4357 Tuscan St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14 1927

7 AGE Years Months Days IF LESS than 1 day 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Chas H Teehner

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Eva L Hettel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md

14 Informant Chas H Teehner

(Address) 4357 Tuscan St

Filed ... 19 C. HAMPSON YEL M.D. Registrar

Per

NOV 16 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14, 1927

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 6.35 P. m.

The CAUSE OF DEATH* was as follows:

Patent Ductus Arteriosus

(duration) ... yrs. ... mos.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James L Wiegand M.D.

11/15, 1927 (Address) 1729 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: Nov 16 1927

20 UNDERTAKER: George J Smith — ADDRESS: 153 L Hollins

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. ... should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.F.S.—400 Lbs.

E 27501 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27501

CERTIFICATE OF DEATH.

Registered No. 27

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin ave. near Cedar ave. St. 21st Ward) Raspeburg

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F. Regina

(a) Residence No. Franklin ave near Cedar ave. St., Raspeburg Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 2 yrs. mos. ds. How long in U. S., if of foreign birth? 6 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Regina

6-DATE OF BIRTH (month, day and year) July 5th 1859

7-AGE. 68 yrs. 4 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer.....

9-BIRTHPLACE (city or town) Trutenwitz (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Magdalena Schmitzer

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country), Germany

11- (Informant) Rosa Regina

(Address) Raspeburg Md.

13- C. HAMPSON JONES, M. D.

192 Registrar.

NOV 16 1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 15th 1927

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 1927 to Nov 15 1927

that I last saw him alive on Nov 14 1927

and that death occurred, on the date stated above, at 10 50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

3 years (Duration)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Smith M. D.

Nov. 16 192 (Address) 920 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. Nov. 18 1927

20-UNDERTAKER. Weller Funeral Home

ADDRESS Fullerton

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27502

CERTIFICATE OF DEATH.

21 E 27502

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. JOHNS HOPKINS HOSPITAL ST. 23-31 WARD)

2-FULL NAME John Goble

(a) RESIDENCE No. 702 E. Hanover ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	10 mos.	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Illinois

12 MAIDEN NAME OF MOTHER Liliaw Foster

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Account JOHNS HOPKINS HOSPITAL
(Address)

15 Filed NOV 16 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1927, to Nov. 15, 1927, that I last saw him alive on Nov. 15, 1927 and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:
Erysipelas.

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) J. S. Bennett M. D.
11/15, 1927 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampden: Va. DATE OF BURIAL Nov 16 27.

20 UNDERTAKER Fred. A. Wilmes & Co. ADDRESS 703 Hanover St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 27503

HEALTH DEPARTMENT—CITY OF BALTIMORE

1927 E 27503

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. from Balto 572 miles out at sea on SS Verona St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No.)

2-FULL NAME ~~Edward Baltzer~~ Charles Baker a.k.a. 11/24/78

(a) RESIDENCE NO. Wheelersburg Ohio St. _____ Ward Fireman

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 3 yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal Passer
(b) General nature of Industry, business, or establishment in which employed (or employer) ooo
(c) Name of employer

9 BIRTHPLACE (city or town) /
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 Informant Dr Riley
(Address) Broadway & Lancaster St

Filed NOV 16 1927 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11. 27 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Vertebra caused by accidentally down hatchway of SS Verona

2 days (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

Nov 14 (Signed) W. J. Riley M. D.
(Coroner)
, 19 27 (Address) 1029 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — Date of Burial 11/16 1927

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 27504

CERTIFICATE OF DEATH.

E 27504
1-PLACE OF DEATH

REGISTERED NO. 12-51
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2437 Maryland Ave. (ST.) (WARD)

2-FULL NAME Mary Elizabeth Bosley

(a) RESIDENCE NO. 2437 Maryland Ave ST.
(Usual place of abode) WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 18, 1846

7 AGE — Years: 81 — Months: 9 — Days: 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS
10 NAME OF FATHER: Peter Bosley
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Rosalba Marqueau
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mr Albert H. Bedford
(Address): Hampton Courts Washington D.C.

15 Filed: NOV 16 1927 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1927, to Nov 14, 1927, that I last saw h alive on Nov 13, 1927, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis
Hypostatic Pneumonia

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) John A Evans, M. D.
, 19 (Address) 612 W 40th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Nov 17 1927

20 UNDERTAKER: Wm J Tickner Sons — ADDRESS: Norfolk Va

NOV 16 1927

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 E 27505

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2310 N. Fulton Ave ST. 13-59 WARD)

2-FULL NAME Rosalind Carrier Kramer

(a) RESIDENCE NO. 2310 N Fulton Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 12 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	21	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Public City 068

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Frederick Kramer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Augusta Mau

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Augusta Kramer

(Address) 2310 N Fulton

Filed NOV 16 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1927, to Nov. 15, 1927,

that I last saw her alive on Nov. 15, 1927

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert L. Mitchell, M. D.

Nov. 16, 1927 (Address) 2111 Wyoming Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Nov 16 1927

20 UNDERTAKER: J. Wm. Redmond Sons

ADDRESS: Baltimore

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27506

CERTIFICATE OF DEATH.

74-001

E 27506

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1662 W. Northern Ave. Ward) 18-59

2-FULL NAME Susan Ballard

(a) RESIDENCE NO. 1662 W. North Ave. Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Levin E. Ballard. quin

6 DATE OF BIRTH (month, day, and year): Aug. 28, 1850

7 AGE — Years: 77 — Months: 2 — Days: 17 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Adams Co

(State or country): Pa

PARENTS

10 NAME OF FATHER: Peter Long.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Mrs James J. Glenn

(Address): 1662 W. North Ave

15 Filed _____ 19__ _____ Registrar

NOV 16 1927 C. HAMPSON GIBSON, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Acute Heart Disease

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. T. Hamilton M. D.

(Coroner)

19 (Address) 735 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the state ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Nov 17 1927

20 UNDERTAKER: Wm Tuckner Sons ADDRESS: Ford & Pa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 27507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

186-003 E 27507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: No. 1731 N. Broadway (8-17 Ward)

2-FULL NAME Henry Wm. Kramer

(a) RESIDENCE NO. 1731 N. Broadway Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna R. Kramer

6 DATE OF BIRTH (month, day, and year) Jan. 3, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Engraver

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Wm. Kramer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Kamps

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Sadye Marks

(Address) 203 N. Plum St. Richmond Va

15 Filed NOV 16 1927 19

C. HAMPSON JONES, M. D.

Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia following automobile accident on Oct 31/27 at Broadway & Lanvale St.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Weis M. D.

(Coroner)

, 19 27 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial Nov 17 19 27

20 UNDERTAKER M. Wickner & Sons ADDRESS Norfolk Va

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27508

CERTIFICATE OF DEATH.

74-001

E 27508

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1303 N. Gilmor St. 15-27 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Drucilla Allen

(a) RESIDENCE NO. 1303 N. Gilmor St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year): About 1875

7 AGE: Years 52 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: General

9 BIRTHPLACE (city or town):

(State or country): Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Elsie Allen

(Address) 1423 Frankland

15 Filed NOV 16 1927

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.), thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) C. H. Jones M. D.
(Coroner)

19 (Address) 2512 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Date of Burial Nov. 17 1927

20 UNDERTAKER: Virginia E. Brooks ADDRESS 1463 N. Carey St

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 27509

CERTIFICATE OF DEATH

E 27509

1-PLACE OF DEATH — University Hospital

REGISTERED NO.

City of BALTIMORE: (No. Lombard and Greene St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Laufe

(a) RESIDENCE NO. 725 W. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3 1893

7 AGE — Years: 34 — Months: 6 — Days: 12 — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrical Worker

(b) General nature of industry, business, or establishment in which employed (or employer): C.T.

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Ougard Laufe

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER — Schaberum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs Augusta Laufe

(Address) 725 W. Lombard

Filed NOV 16 1927 HAMPSON JONES, M. D. Registrar

By RHM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1927, to Nov. 15, 1927.

that I last saw him alive on Nov. 15, 1927.

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis Adelaide Laufe, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

Date of Burial: Nov 18 1927

20 UNDERTAKER: Jos Jourdan's Son

ADDRESS 217 S Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27510

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST. WARD)

2-FULL NAME William B Thompson

(a) RESIDENCE No. 26 N Church st ST. Pa WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie A Thompson

6 DATE OF BIRTH (month, day, and year) Sept 17 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Parma

PARENTS

10 NAME OF FATHER Isaac Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Parma

12 MAIDEN NAME OF MOTHER Sarah Cossmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm A Thompson (Address) 19 N Front St

15 Filed NOV 16 1927 J. C. HAMILTON, Registrar by R. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1927, to Nov. 16, 1927, that I last saw him alive on Nov. 16, 1927, and that death occurred, on the date stated above, at 8-10 A m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

Chronic Intestinal Obstruction

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct 25 / 27

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Post mortem

(Signed) George O. Eaton, M. D.

, 19 (Address) Bon Secours Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wagnersboro, Pa	11/16/27
20 UNDERTAKER George A Farley	ADDRESS Fulton-Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27511

CERTIFICATE OF DEATH.

129 E 27511

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1442 Light St. 23 - 31 WARD)

2-FULL NAME Annie Klingenbergs

(a) RESIDENCE No. 1442 Light ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Klingenberg

6 DATE OF BIRTH (month, day, and year) 7-4-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	84	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Mon.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jo Biddle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. Klingenbergs 1442 Light St.

15 Filed NOV 16 1927 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1927, to Nov 14, 1927, that I last saw h[illegible] alive on Nov 14, 1927, and that death occurred, on the date stated above, at 2 17 m

The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic nephritis unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) [illegible], M. D.

11-15, 1927 (Address) 1219 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL 11/17 1927

20 UNDERTAKER D. Few McCully — ADDRESS 130 E Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Emergency Permit issued by Health Commissioner

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27512

CERTIFICATE OF DEATH.

14th E 27512

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 E. Pratt St., 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Leroy Pusey

(a) RESIDENCE NO. 605 E. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced (or) WIFE of Leonard M. Pusey

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	27	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edward Momus (Sister)

(Address)

15 Filed NOV 15 1927, 19 C. HALL JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1927

17

I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 .

that I last saw h alive on , 19 .

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Baltimore Health

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis - Md

DATE OF BURIAL Nov 16 1927

20 UNDERTAKER Edward Momus

ADDRESS Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27513

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. E 27513

1-PLACE OF DEATH

City of BALTIMORE: (No. 430 N Moore St., 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Bracco

(a) RESIDENCE NO. 430 Moore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Bracco

6 DATE OF BIRTH (month, day and year): July 18 1881

7 AGE: Years 46 Months 3 Days 25 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER: Romulus Bracco

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER: Emma Moore

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant: Jos Bracco.

(Address) 134 Madison Ave.

15 Filed 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 23 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 4 days

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

Signed J. H. Hennessy M. D. (Coroner)

1927 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

Date of Burial: Nov 27 1927

20 UNDERTAKER: Samuel H Kunkel

ADDRESS: 1128 Bank

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27514

CERTIFICATE OF DEATH.

REGISTERED NO. E 27514

1-PLACE OF DEATH

City of BALTIMORE: (No. Mt. Sam. Hospital 14-27 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elliott Burke

(a) RESIDENCE NO. 500 N. Dickeman Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leanna Butler

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad.

(c) Name of employer Penna R.R.

9 BIRTHPLACE (city or town) Greenwood S.C. May 27

(State or country)

PARENTS

10 NAME OF FATHER Mrs. Butler

11 BIRTHPLACE OF FATHER (city or town)

(State or country) S.C.

12 MAIDEN NAME OF MOTHER Mary Wms

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S.C.

14 Informant Annie Butler

(Address) 760 N. Stricker St.

Filed 19

Per

C. HAMPSON JONES, M. D.

Registrar

NOV 16 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov. 13 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound in left lung

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Homicide

(duration) yrs. mos. ds.

(Signed) J. P. Hennig M. D.

(Coroner)

18 (Address) 2572 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood S.C. Date of Burial 11/16 1927

20 UNDERTAKER Samuel Hennig Jr. ADDRESS 2572 Edmondson Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12 9 25—A Co.—200 Bks.

(Carey)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27515

CERTIFICATE OF DEATH.

74-06

E 27515

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1410 W. Lafayette Ave 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Carey

(a) RESIDENCE NO. 1410 Lafayette Ave Ward

(Usual place of abode) since birth 52

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race C

5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Linwood Smith

(Address) 1410 W Lafayette Ave

NOV 16 1927 19 C. HAMPSON JONES, M. D. Registrar

Par Arth

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15/27 19

17

I HEREBY CERTIFY, That I attended deceased from 10/26/27 to 11/15/27,

that I last saw her alive on 11/14/27,

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hawk M. D.

11/16, 1927 (Address) 912 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Date of Burial Nov 18 1927

20 UNDERTAKER Wm H Crawford Son ADDRESS 1400 Madison

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. USE INDELIBLE INK—THIS IS

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27516

90 E 27516

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3333 N. Charles St. 12-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Wells

(a) RESIDENCE NO. 3333 N. Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10, 1855,

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Flour & Feed

(c) Name of employer R. C. Wells

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Nathaniel B. Wells

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Leonora Lauderman

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Miss Georgia Wells

(Address) 3333 N. Charles st

V 16 1927 C. HAMPSON JONES, M. D. Registrar

Per WPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 1927, to Nov 14, 1927, that I last saw h.. alive on Nov 14, 1927, and that death occurred, on the date stated above, at 8 30 p m.

The CAUSE OF DEATH* was as follows:

Puerperal Shock

(duration) yrs. 1/3 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobular. Cardiac Hypostasis

(duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 13 '27

Was there an autopsy? yes.

What test confirmed diagnosis? by Dr.

(Signed) Alma B Lauman M. D.

11-15-1927 (Address) 718 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem. Date of Burial Nov. 17 1927

20 UNDERTAKER Wm. A. Black ADDRESS 927 N. Broadway

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27517

139 E 27517

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

City of BALTIMORE: (No. — St., 7-13 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Miss Sophie Schach

(a) RESIDENCE NO. 819-N. Broadway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 2-1888

7 AGE: Years 39 Months 9 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Mrs. Samuel Heinemann

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Andrae Schach

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherina Keith

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant Mrs. John Russer

(Address) 819 N. Broadway

V 16 1927 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 November 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1927, to Nov 15, 1927, that I last saw h alive on Nov 15, 1927, and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH* was as follows:

(1) Fibroid Uterus

(2) Embolism

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure 20 min

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! Yes Date of 11-12-27

Was there an autopsy?

What test confirmed diagnosis! Path + clinical findings

(Signed) C. Hyman, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial Nov. 18 1927

20 UNDERTAKER: Wm. C. Black ADDRESS 927 N. Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27518

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27518

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 54

CITY OF BALTIMORE: (No.) Balto Md (St.) 5-8 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel McCoulough

(a) RESIDENCE No. 620 N. Eden Alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis McCoulough

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Baltimore City Hospts (Address) Balto Md.

15 Filed NOV 16 1927, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15 1927

17

I HEREBY CERTIFY, That I attended deceased from 10-24- 1927 to 11-15- 1927,

that I last saw he alive on 11-14- 1927

and that death occurred, on the date stated above, at 8.40 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure,

Pellagara

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Psychosis w/ Pellagara

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Harry Eldon Kay M. D.

11/15 1927 (Address) Baltimore City Hospitals,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westport Cemetery DATE OF BURIAL Nov 20 1927

20 UNDERTAKER J. A. Wilson ADDRESS 515 Mc Elderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27519

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 16-37 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Murray

(a) RESIDENCE No. BALTIMORE CITY HOSPITALS ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ?. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant. (Address) Records

15 Filed NOV 16 1927, 19 Per 1209 C. H. Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/10/ 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1927 to Nov. 10, 1927 that I last saw him alive on Nov. 10, 1927 and that death occurred, on the date stated above, at 11:40 A. m.

The CAUSE OF DEATH* was as follows:

myocarditis chronic + acute
arteriosclerosis general + cerebral
hypertension

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Sale.

(Signed) C. Hampson Jones M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL NOV 19 19

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

BALTIMORE CITY HOSPITALS

UNIVERSITY OF MARYLAND

Spec.—1-12-23—M&T—500 Blks.

E 27520

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-001
16 E 27520

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Hanover ST. 12-30 WARD)

2-FULL NAME Baby De Ween —

(a) RESIDENCE NO. 612 Hanover ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-15-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or 20 min.
	—	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore —
(State or country) Maryland

PARENTS
10 NAME OF FATHER William Francis De Ween
11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary Margaret Callender
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Mary Margaret De Ween
(Address) 612 Hanover Street —

15 Filed NOV 16 1927, 19
Per C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15 1927

17
I HEREBY CERTIFY, That I attended deceased from 11-15—, 1927, to 11-15—, 1927,
that I last saw h/M DEAD alive on 11-15—, 1927,
and that death occurred, on the date stated above, at 1:10 P m.
The CAUSE OF DEATH* was as follows:

Prematurity. —

(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Premature Birth
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis? No test but no respiration
(Signed) M. Alexander Rovey M. D.
11/15, 1927 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL NOV 19 1927

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—1-12-23—M&T—500 Bks.

E 27521

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27521

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 Edgewood St ST. 15-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Leigh Becker

(a) RESIDENCE NO. 1901 Edgewood St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary Elizabeth Becker

6 DATE OF BIRTH (month, day, and year) Sept 1/1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lehigh Portland Cement Co

9 BIRTHPLACE (city or town) (State or country) Barrington Ill.

PARENTS

10 NAME OF FATHER John Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Leona Newcombe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont

14 Informant Mary E Becker

(Address) 1901 Edgewood St

15 Date NOV 16 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1927, to Nov. 15, 1927, that I last saw him alive on Nov. 15, 1927, and that death occurred, on the date stated above, at 10. p. m.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

(duration) About 1 year yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical Exam.

(Signed) W. Hoffman, M. D.

, 19 (Address) 1102 No. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lake Hill Cemetery Chicago Ill — DATE OF BURIAL: Nov 19 1927

20 UNDERTAKER: Harry H Armacost — ADDRESS: 1204 Edgewood St

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIAN'S should state EXACTLY. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27522 E 27522

REGISTERED NO. 20-70

1-PLACE OF DEATH

City of BALTIMORE: (No. 3311 Edmondson Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Henry White

(a) RESIDENCE NO. 3311 Edmondson Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. White

6 DATE OF BIRTH (month, day, and year) April 6, 1883

7 AGE	Years	Months	Days
	44	7	9

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grain Weigher

(b) General natore of indostry, boslness, or establishment in which employed (or employer)

(c) Name of employer Western Md. Ry. Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert T. White

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER (?) Banks

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Mary L. White

(Address) 3311 Edmondson Ave.

15 Filed 16 1927 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 15, 1927 19

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1927, to Nov. 15, 1927,

that I last saw him alive on Nov. 15, 1927,

and that death occurred, on the date stated above, at 7 A.M. m.

The CAUSE OF DEATH* was as follows:

Right Lobar Pneumonia.

(doration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Nathaniel Henry White M. D.

Nov 17, 1927 (Address) 1830 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injory, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial 11/17/27 19

20 UNDERTAKER Rasp & Cook ADDRESS 1000 Baltimore St.

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 27523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-803

E 27523

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Rogers & Park Heights Ave. St. 27-55 Ward)

2-FULL NAME Virginia Lee Clary

(a) RESIDENCE NO. 5423 Park Heights Avenue St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 1917

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	10	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Martinsburg

(State or country) W. Virginia

PARENTS

10 NAME OF FATHER Albert Wright Clary

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sally Aler

13 BIRTHPLACE OF MOTHER (city or town) Martinsburg

(State or country) Virginia

14 Informant Mrs. Sally Clary

(Address) 5425 Park Heights Ave.

15 Filed 4/16 1927 19 C. HAMPSON JONES, M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 15, 1927 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

THE CAUSE OF DEATH* was as follows: Fractured Skull & Internal Injuries due to Auto Accident

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) _____ M. D.
(Coroner)

4/16, 1928 (Address) 3672 Roland Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Date of Burial 11/17/27 19

20 UNDERTAKER [illegible] & Cook ADDRESS 1062 W. Baltimore

don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

(Arthur Grigory)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27524

CERTIFICATE OF DEATH.

E 27524

1-PLACE OF DEATH

City of BALTIMORE: (No. Mun. Hosp Ward 27-30)

2-FULL NAME Arthur Grigory

(a) RESIDENCE NO. 523 S Fremont St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE: Years 40 yrs Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) S C

(State or country)

PARENTS

10 NAME OF FATHER Arthur Grigory

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Susan Fuller

13 BIRTHPLACE OF MOTHER (city or town) S C

(State or country)

14 Informant Frank Fuller

(Address) 640 Montgomery

15 C. HAMPSON JONES, M. D. Registrar

For Roth

16 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 192 7

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest or inquiry as required)

on the day stated above, and that said deceased came to death (Verdict or inquiry.)

between and from the evidence obtained by said Inquest

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Signed M. D.

11/27 19 (Address) 1437 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the state yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cmty Date of Burial 11/17 1927

20 UNDERTAKER: J Leon Hall ADDRESS 753 Lombard

(tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27525

CERTIFICATE OF DEATH.

E 27525

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 31 st St. & Crestmont Ave St. 27-53 Ward)

2-FULL NAME Edith Totten

(a) RESIDENCE NO. Belvedere Ave., Roland Park St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7/1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Col Enoch Totten

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Wooster, Ohio

12 MAIDEN NAME OF MOTHER Mary Hohe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Green Bay, Wis.

14 Informant John T. Flannery

(Address) Washington, D.C.

19 C. Hampson Jones M.D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15/27

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. Edw Carter (Coroner) M. D.

19 (Address) 1/16/27 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 1927

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. Date of Burial Nov 17 1927

20 UNDERTAKER A. Wagenheim & Sons ADDRESS Eutaw & Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 27526

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27526

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balt City Hospital ST. 16-22 WARD)

2-FULL NAME Sarah G. Deleher

(a) RESIDENCE NO. 1224 N Patterson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Deleher.

6 DATE OF BIRTH (month, day, and year): — 1877

7 AGE: Years 50? Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Benjamin Bray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susanna Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Josephine Caldwell.

(Address) 1388 Stockton St.

15 Filed: 11/17, 19 27 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-13 1927

17 I HEREBY CERTIFY, That I attended deceased from 9-23-, 19 27 to 11-13, 19 27

that I last saw her alive on 11-13, 19 27

and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

Contributory emos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) ..... M. D.

, 19 (Address) Balt City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 11/17, 19 27

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Presstman St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27527

CERTIFICATE OF DEATH.

51 E 27527

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 618 N. Mount St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey Thelma Harris

(a) RESIDENCE NO. 618 N. Mount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mns. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-11-1918

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	9	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.,

(State or country) Md

PARENTS

10 NAME OF FATHER Liston Harris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Virginia A. Carter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Virginia A. Harris

(Address) 618 N Mount St

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 11- , 1927, to Nov 14 , 1927,

that I last saw h.e alive on Nov 14- , 1927,

and that death occurred, on the date stated above, at 4P. m.

The CAUSE OF DEATH* was as follows: Acute Inflamatory Rheumatism

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 2 ds.

Is Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Marcellus E. Toney, M. D.

, 19 (Address) 1748 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mt Auburn Cemetery. 11/17—1927

20 UNDERTAKER — ADDRESS

Thomas E. Kelson — 1307 Pressman St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27528
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

179 E 27528
REGISTERED NO.

City of BALTIMORE: (No. St Agnes Hospital St. 10-69 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mr Richard Coady

(a) RESIDENCE NO. 110 S. Catherine St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Coady

6 DATE OF BIRTH (month, day, and year) Aug 15-1875

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
52	3	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) O&B
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Phila - Pa

PARENTS

10 NAME OF FATHER Andrew Coady

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Cath Bullger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant Mrs Annie Coady
(Address) 110 S. Catherine St

15 FILED NOV 17 1927 C. HAMPSON JONES, M. D. Registrar
By RMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
11-15-27

17
I HEREBY CERTIFY, That I attended deceased from 10-22, 19 27, to 11-15, 19 27, that I last saw him alive on 11-15, 19 27, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

* (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydro Peritoneum

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L. Dalaglacca M. D.
, 19 (Address) St Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial Nov 18th 1927

20 UNDERTAKER John F. Cowan & Son ADDRESS 901 Hollins St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27529

CERTIFICATE OF DEATH

129 E 27529

1-PLACE OF DEATH Md Emerg Hospital REGISTERED NO.

City of BALTIMORE: (No. 4-50 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Prue Chenoweth

(a) RESIDENCE NO. 2635 Greenmount Ave St. Ward Balto Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Caucn

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William J. Chenoweth

6 DATE OF BIRTH (month, day, and year): 7-28-1859

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
68	68	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): above

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert Cassley

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Delta Pa.

12 MAIDEN NAME OF MOTHER: Emelia Prue

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Baltimore Md

14 Informant: William J. Chenoweth

(Address): 2635 Greenmount ave

Filed NOV 17 1927, 19 C. HAMPSON JONES, M. D. Registrar

Per R.P.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-16-1927

17

I HEREBY CERTIFY, That I attended deceased from 11-14-27, 19..., to 11-16-27, 19...,

that I last saw her alive on 11-16-27, 19... p.m.

and that death occurred, on the date stated above, at 4 45 m.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Hypertension & Nephritis

(duration) 38 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Apoplexy

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Clinical Course

(Signed) Geo A. Guthrie, M. D.

19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — Date of Burial: 11/19 1927

20 UNDERTAKER: [illegible] — ADDRESS 502 E Madison

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

White 2220 Dr

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27530

CERTIFICATE OF DEATH.

90 E 27530

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Victoria Ave Hamilton ST. 37/43 WARD)

2-FULL NAME Jennie E. Merryman

(a) RESIDENCE No. 12 Victoria Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wilbur Merryman

6 DATE OF BIRTH (month, day, and year) July 12 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS
10 NAME OF FATHER Shuman James
11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Mrs Horace Scopinich
(Address) 12 Victoria Ave Hamilton

15 Filed NOV 17 1927 C. HAMPSON JONES, M. D., Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1927, to Nov 15, 1927, that I last saw her alive on Nov 15th, 1927 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Myocardial degeneration
Uremia Coma

(duration) yrs. mos 1 ds.
CONTRIBUTORY (Secondary) Cirrhosis Alcoholic, Hypertrophic

(duration) 1 yrs. mos. ds.
18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms
(Signed) Thomas J Walsh M. D.
, 19 (Address) 532 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery
UNDERTAKER William Cook
DATE OF BURIAL 11/16 1927
ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-002

E 27531

REGISTERED NO. E 27531

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 27531

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., 8-17 Ward)

2-FULL NAME Unknown Male

(a) RESIDENCE NO. 1326 No Bway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

6a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years about 78 Months Days IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): John Welsh 336 Lynndale Ave.

15 Filed NOV 17 1927 C. HAMPSON JONES, M. D. Registrar

By A K K

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry and Lic (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis

Exhaustion 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. ... ds.

(duration) yrs. ... ds.

M. D.

19 (address) 1437 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Com. Date of Burial 11/17 1927

20 UNDERTAKER: Wm Cook ADDRESS 502 E North

Cor.—12-9-25—A Co.—200 Blks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27532

CERTIFICATE OF DEATH.

100-001 E 27532

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 410 N. Hoffman St. Ward)

2-FULL NAME Charles G. Speed

(a) RESIDENCE NO. 410 N. Hoffman St. Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: colored | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1915

7 AGE: Years 11 | Months 11 | Days 12 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Leon Speed

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Cohen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Betty Speed

(Address) 410 N. Hoffman St

Filed NOV 17 1927. E. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov. 14 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Stevens (Coroner) M. D.

Nov 17 1927 (Address) 2592 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery Date of Burial Nov 17 1927

20 UNDERTAKER: Edward Bryan ADDRESS 1631 orleans st

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12 23—M&T—500 Blks.

Colleren,

E 27533 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-001

E 27533

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231-S. Chester ST., 1-3 WARD)

2-FULL NAME Irena Catharine Callaren

(a) RESIDENCE NO. 231-S. Chester ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph L. Callaren

6 DATE OF BIRTH (month, day, and year) Feby 12/1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	28	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Jos Morgenroth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Mathia Funk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Mrs Jos Morgenroth (Address) 231 S Chester St

15 Filed NOV 17 1927 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/13 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 . 1926 . to Nov 13 . 1927 . that I last saw her alive on Nov 12 . 1927 . and that death occurred, on the date stated above, at 11 05 A m.

The CAUSE OF DEATH* was as follows:

1 Pernicious Anaemia (duration) yrs. 15 mos — ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy (duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab —

(Signed) Gustav Goldmann, M. D.

. 19 (Address) 636 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery DATE OF BURIAL 11/16 1927

20 UNDERTAKER D. L. A Moran ADDRESS 3000 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27534

CERTIFICATE OF DEATH.

74-001

74 E 27534

REGISTERED NO. 2622

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 North Arlington Ave. St.; 18 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Watts

(a) RESIDENCE NO. 515 North Arlington Ave St. 18 Ward Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Maried

5a If married, widowed, or divorced HUSBAND of Harriett Watts (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17, 1896

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Baker

(b) General nature of industry, business, or establishment in which employed (or employer) Gardening

(c) Name of employer None

9 BIRTHPLACE (city or town)

(State or country) Bent Creek Va.

PARENTS

10 NAME OF FATHER Pompie Watts

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bent Creek Va

12 MAIDEN NAME OF MOTHER Harriette Battles

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bent Creek Va.

14 Informant William H. Watts Nephew

(Address) 515 N Arlington Ave

NOV 17 1927

15 FILED 19 C. HAMPSON JONES, M. D. Registrar

Per R.W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Nov. 15th 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1927, to Nov. 15th, 1927, that I last saw him alive on Nov. 15, 1927, and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) Nine hours. yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial sclerosis

(duration) Indefinite mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Ernest C. Melton, M. D.

, 19 (Address) 2001 Penna. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial Nov 19 1927

20 UNDERTAKER Thomas E. Whyte ADDRESS 1364 N Carey

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Augusta Emelia Behnke

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27535

CERTIFICATE OF DEATH

90

E 27535

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 420 N Lemmert Ave St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Emelia Behnke

(a) RESIDENCE NO. 420 N Lemmert St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. da. How long in U. S. if of foreign birth? 37 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl A. Behnke

6 DATE OF BIRTH (month, day, and year): Nov 7th 1852

7 AGE: Years 75 Months 8 Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Julius Burjak

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant Bonnie Johnson

(Address) 420 N Lemmert Ave

Filed 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15th 1927

17 I HEREBY CERTIFY, That I attended deceased from July 1 1927 to Nov 15 1927

that I last saw her alive on Nov 15 1927

and that death occurred on the date stated above, at 5:13 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred Burjak M. D.

19 (Address) 420 N Lemmert Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmanuel

Date of Burial 11/18 1927

20 UNDERTAKER: J Neumann

ADDRESS 375 S. Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 17 1927

Spec.–7-17-26—A Co.—200 Bks.

Oliver

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27536

CERTIFICATE OF DEATH

38

E 27536

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. St. Joseph's Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert H. Oliver, Jr.

(a) RESIDENCE NO. 2742 Hudson St. / Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence In city or town where death occurred 55 yrs. 4 mos. 2 ds. How long In U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of the late Ethel M. Oliver

6 DATE OF BIRTH (month, day, and year) July 14th 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER James R. Oliver

11 BIRTHPLACE OF FATHER (City or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Nina de Comis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.

(State or country)

14 Informant Herbert W. Oliver Jr.

(Address) 2729 E. Eager St

Filed NOV 17 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 11/16/27

17 I HEREBY CERTIFY, That I attended deceased from 11/3/27, 19..., to 11/16/27, 19...,

that I last saw h alive on 11/16/27, 19...,

and that death occurred, on the date stated above, at 7:20 P.m.

The CAUSE OF DEATH*, was as follows:

Syphilis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Lawrence Fahnestock M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial Nov. 19th 1927

20 UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wolfe St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 27537

113 E 27537

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2648 Huntingdon Ave (ST.) (WARD) 51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie May Oates

(a) RESIDENCE NO. 2648 Huntingdon Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yr yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 15 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER James A. Oates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Faison N. C

12 MAIDEN NAME OF MOTHER Ella O. Horn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. James A. Oates

(Address) 2648 Huntingdon Ave

15 Filed NOV 17 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 19 27

17

I HEREBY CERTIFY, That I attended deceased from Nov 8th, 19 27, to Nov 15, 19 27, that I last saw h— alive on Nov 15, 19 27, and that death occurred, on the date stated above, at 7. P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Antedating one month (duration) yrs mos ds.

CONTRIBUTORY (Secondary) General malaise of cardiac origin with Convulsions (duration) yrs. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs and Symptoms

(Signed) Robt. B. Wormald, M. D.

, 19 (Address) 3643 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's, Hampden	Nov 17 19 27

20 UNDERTAKER D. A. Marshall ADDRESS 3539 Old Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27538

CERTIFICATE OF DEATH.

112

REGISTERED NO. E 27538

1-PLACE OF DEATH

City of BALTIMORE: (No. 240 S Dallas St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Bowman

(a) RESIDENCE NO. 240 S Dallas St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C

5 Single, Married, Widowed, or Divorced. (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Bowman

6 DATE OF BIRTH (month, day, and year): unknown 1854

7 AGE: Years 73 Months Days. IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Albert Bowman

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Mildred Landon

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Ella Bowman

(Address) 204 S Dallas St

Filed NOV 17 1927 19 H. MASON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 13 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Diarrhea

Arteriosclerosis

Exhaustion

(Duration) ..... mos. 6 hrs.

CONTRIBUTORY (Secondary)

Senility (Duration) ..... mos. 1 hrs.

Witness my hand this 14 day of Nov 19 27 M. D.

(Address) 143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial: Nov. 17 1927

20 UNDERTAKER: Milton Davis — ADDRESS: 316 N Eden St

Be stated EXACTLY. PHYSICIANS should be stated. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 27539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 27539

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2518 Guilford ST. 12-50 WARD)

2-FULL NAME Henriette Pehl.

(a) RESIDENCE NO. 2518 Guilford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Name of Cemetery supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Pehl

6 DATE OF BIRTH (month, day, and year): April 27, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germ

12 MAIDEN NAME OF MOTHER: Sybilla Grodt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germ

14 Informant: Bertha Pehl

(Address) 2518 Guilford Ave.

15 Filed NOV 17 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1927, to Nov. 16, 1927, that I last saw h e alive on Nov 15, 1927 and that death occurred, on the date stated above, at 4 16 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Apoplexia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Senility.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

, 19 (Address) 612 W 40 th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov 1927

20 UNDERTAKER: George J. Smith

ADDRESS 153 E Hollins

Spec.—1-10-21—M&T—1500 Bks.

Helene Kleinkauf

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27540 — E 27540

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 E. Hamilton Ave., ST. 76-43 WARD)

Raspeburg, Md.

2-FULL NAME Helene Kleinkauf

(a) RESIDENCE NO. 12 E. Hamilton Ave., ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of John Kleinkauf

6 DATE OF BIRTH (month, day, and year) Jan. 7, 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
01	2 10	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hessen-Dornsvadt, Germany

PARENTS

10 NAME OF FATHER Philip August Planty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hessen, Dornsvadt, Germany

12 MAIDEN NAME OF MOTHER Elizabeth Kornmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hessen, Dornsvadt, Germany

14 Informant Mr. & Mrs. L. Stanley Price

(Address) 12 E. Hamilton Ave., Raspeburg, Md.

15 Filed NOV 17 1927 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15, 19 27

17

I HEREBY CERTIFY, That I attended deceased from August 25th, 19 26, to November 15th, 19 27,

that I last saw her alive on November 15th, 19 27,

and that death occurred, on the date stated above, at 1:10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. L. Williamson, M. D.

11/16 19 27 (Address) 5713 Belair Rd., Raspeburg, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	NOV 18 1927
20 UNDERTAKER George J. Smith	ADDRESS 153 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27541

CERTIFICATE OF DEATH.

E 27541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Christs Institution Hospital

CITY OF BALTIMORE: (No.) 708 Ensor St (ST.) 10-14 (WARD)

2-FULL NAME William P. Cook

(a) RESIDENCE NO. Havre de Grace Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER W. P. Cook Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record.

(Address)

15 [illegible] S. HAMPSON JONES, M. D.

Registrar

NOV 7 1927.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1927

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to Nov. 16, 1927,

that I last saw him alive on Nov. 16, 1927,

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Carcinomia of Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinomia of Liver

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Havre de Grace Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive

(Signed) Dr G W Kennard, M. D.

11-16 1927 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace Md DATE OF BURIAL 11-17 1927

20 UNDERTAKER A. Pennington & Son ADDRESS Havre de Grace Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 27542

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27542

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 216 E Cross St. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — Claire Edw. Thompson

(a) RESIDENCE No. 216 E Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Francis Thompson

6 DATE OF BIRTH (month, day, and year) — April 17-1874

7 AGE: Years 53 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Roadhouse man

(b) General nature of industry, business, or establishment in which employed (or employer) — Produce man

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER — John F. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER — Alice Dolphin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant — Mary Ann Thompson

(Address) 216 E Cross St.

15 [illegible] THAMPSON JONES, M. D.

Registrar

NOV 17 1927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 7 1927, to Nov 16 1927.

that I last saw h[illegible] alive on Nov 16 1927.

and that death occurred, on the date stated above, at 6.30a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — Influenza

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O Mitchell M. D.

1927 (Address) 1249 William St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	11-19 1927
20 UNDERTAKER	ADDRESS
E H Hoke	1156 W Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ALL blanks should be filled. Abbreviations not to be used. Items should be stated EXACTLY. PHYSICIANS should state

Cor.—12-9-25—A Co.—200 Bks.

E 27543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mir Hosp. St., 4-30 Ward)

REGISTERED NO. L 27543

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl F. Lange

(a) RESIDENCE NO. 25 Delroy Ave (Catonsville) St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 Color or Race White | 5 Single, Married, Widowed, or Divorced. (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Lange.

6 DATE OF BIRTH (month, day and year) March 14 1888

7 AGE

Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
39	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Stripper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Martha Lange

(Address) 25 Delroy Ave Catonsville

Filed NOV 17 1927 C. HAMPSON JONES, M. D. Registrar

For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1927

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry find that said decreased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Otitis Left. Junior

Sept 18 & Nov 15/27

Contributory (Secondary) Acute Otitis Hemorrhagica

Nov 15/27 (Duration) yrs. mos. 1 ds.

(Signed) G C Slade M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 11-18 1927

20 UNDERTAKER Mrs Chas A G Rohde ADDRESS 2327 Edmondson Ave

Not should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 27544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 27544

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1020 Eutaw St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M Stinson

(a) RESIDENCE NO. 1020 Eutaw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Johnson

6 DATE OF BIRTH (month, day, and year) Feb 28 1857

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	68	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer - 45

(b) General nature of industry, business, or establishment in which employed (or employer) Self 0 45

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Priscilla Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Virginia Nelson

(Address) 1020 Eutaw

Filed NOV 17 1927 19 H. HAMPSON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 10 1927 to Nov 14 1927

that I last saw h[illegible] alive on Nov 14 1927

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ex Nausium

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. J. Hughes M. D.

Nov 16 1927 (Address) 1413 E Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial NOV 17 1927 19

20 UNDERTAKER Samuel T Hemsley ADDRESS 1424 Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27545

CERTIFICATE OF DEATH.

E 27545

1-PLACE OF DEATH 105 N. Fiest / Berkley 27 39 REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Bretz

(a) RESIDENCE No. 105 N. Fiest ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Bretz

6 DATE OF BIRTH (month, day, and year) Oct 20th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunch. Room Prop.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Fred. Lazzo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Eliz Countzits

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mrs. Gertrude Grimm

(Address) [illegible]

15 Filed NOV 17 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15 1927

17

I HEREBY CERTIFY, That I attended deceased from 1/10, 1924, to 11/15, 1927, that I last saw h[illegible] alive on 11/15, 1927, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. + mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine + blood examination

(Signed) Edw Drauchen, M. D.

11/17, 19 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery — DATE OF BURIAL Nov. 18 1927

20 UNDERTAKER F. A. Krause & Son — ADDRESS 703 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 2756 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27546

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospl. ST. 2871 (WARD) 11

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.

2-FULL NAME Miss Alice Bellamy

(a) RESIDENCE NO. Harlem Lodge ST. Gundry Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 1880

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
46	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina.

PARENTS

10 NAME OF FATHER Wm. Geo. Bellamy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilmington NC

12 MAIDEN NAME OF MOTHER Mary Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilmington NC

14 Informant Lillie G. Bellamy (Address) Wilmington NC

Filed NOV 17 1927

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17-27 19

17 I HEREBY CERTIFY, That I attended deceased from 11-14-27, 19, to 11-17-27, 19,

that I last saw her alive on 11-17-27, 19,

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis - 3 days.

Peritonitis (general)

Paralytic Ileus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Harlem Lodge.

Did an operation precede death? yes Date of 11-15-27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Cecil M. Hill, M. D.

, 19 (Address) Franklin Square Hospl,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington N C — DATE OF BURIAL Nov 19 1927

20 UNDERTAKER Robert Brookerson — ADDRESS Calhoun Rollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec. 1-27 M-1500 Bks.

E 27547

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

94 001 E 27547

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ~~1716~~ Provident Hospital ST. WARD)

2-FULL NAME Sarah Dent.

(a) RESIDENCE NO. 1716 Druid Hill ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry

6 DATE OF BIRTH (month, day, and year): ? 1867

7 AGE: Years 60; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Minnie Dent 528 Lanvale St

15 Filed NOV 17 1927

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 5 19 27

17

I HEREBY CERTIFY, That I attended deceased from Oct. 10, 19 27, to Nov. 13, 19 27, that I last saw h[illegible] alive on Nov. 12, 19 27, and that death occurred, on the date stated above, at 6.50 A. m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1716 Druid Hill

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. T. Carr, M. D.

11-17-27 (Address) 518 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 11/17/1927

20 UNDERTAKER: Jno. Geo. A. Holland — ADDRESS: 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 27548

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27548

CERTIFICATE OF DEATH.

24-009

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Antonia Frank

(a) RESIDENCE No. Linganitta Rd & Westchester Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3 - 1849

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Christian Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Anna Jung

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Sister Mary Dionysia, Notre Dame Linganitta Rd. City

15 Filed NOV 17 1927 Registrar C HAMPSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov - 16 - 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov - 14 - 1927 to Nov - 16 - 1927, that I last saw her alive on Nov - 16 - 1927, and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral hemorrhage

R. side hemiplegia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. J. Kirby, M. D.

11/16. 1927 (Address) 1106 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Notch Cliff Md | DATE OF BURIAL: Nov 20 1927

20 UNDERTAKER: Frank A. Fink | ADDRESS: 910 N. Gay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27549

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 N. Baltimore St. 14-27 WARD) 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine H. Lancaster

(a) RESIDENCE NO. 1323 N Baltimore ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Louis M. Lancaster

6 DATE OF BIRTH (month, day, and year) Oct. 2, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	/	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife (37)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Howard J. Rock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Marg't T. Gerber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Louis M Lancaster (Address)

15 Filed NOV 17 1927 C. HAMPSON JONES, M. D. Registrar

By ——— Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1927, to Nov. 15, 1927, that I last saw her alive on Nov. 15, 1927 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lober)

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. A. Kreulen M. D.

(Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	11-18 1927.

20 UNDERTAKER Poole Farley. ADDRESS 1810 Eutaw Pl

TION is very important See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

E 27550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-02 E 27550

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto. City Hosp. St. 2-4 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Kmieciak

(a) RESIDENCE NO. 616 S Chapel St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 21 1924

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	3		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...nil

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Kmieciak

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Hazel Cornell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md.

14 Informant Andrew Kmieciak

(Address) 616 S Chapel St.

15 Filed C. HAMPSON JONES, M. D. Registrar

11 7 1927 Acm

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov. 12 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: St. Car. Acc.

Fracture of Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

Nov 17/27 (Signed) G. C. Blade M. D.

19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Stanislaus Cem Nov 17 1927

20 UNDERTAKER — ADDRESS

John M Weber 1803 Fa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

Spec.–7-17-26—A Co.—200 Bks.

E 27551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27551

REGISTERED NO. 27442

1-PLACE OF DEATH

City of BALTIMORE: (No. BALTIMORE CITY HOSPITALS St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Heinz

(a) RESIDENCE NO. 23 Rosemont Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or ~~Divorced~~. (write the word): Married?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Johanna Kirmis?

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 0 Months 5 Days

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Metal worker

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Herman Heinz

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie P.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant BALTIMORE CITY HOSPITALS

(Address) Records.

15 Filed 17 1927 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/10/1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1927, to Nov. 10, 1927, that I last saw him alive on Nov. 10, 1927, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Tabes dorsalis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted ?

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Serum & Spin

(Signed) C Hartman Boyd, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltoem — Date of Burial: Nov 18th 1927

20 UNDERTAKER: Leo G. Cook — ADDRESS: 1723 Pratt St, City

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27552

E 27552

CERTIFICATE OF DEATH

1-PLACE OF DEATH Died in Robb Porcupine Joe's Ambulance in Transit from 1908 W. Franklin St to Bay View Hospital

City of BALTIMORE: (No.

2-FULL NAME Harry Lindon Galloway

(a) RESIDENCE NO. 1906 W. Franklin St Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

REGISTERED NO.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24 1877

7 AGE Years 50 Months 4 Days 22 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat Packer

(b) General nature of industry, business, or establishment in which employed (or employer) not employed at present - not

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Va

(State or country)

PARENTS

10 NAME OF FATHER Jas F. Galloway

11 BIRTHPLACE OF FATHER (city or town) Petersburg Va

(State or country)

12 MAIDEN NAME OF MOTHER Mary Blunt

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Charles C. Knorr

(Address) 1908 W. Franklin St

17 1927 C. HAMPSON JONES, M. D. Registrar

By MCR

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Inquiry thereon and from the evidence obtained by Inquest Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Alcoholism

(duration) 26 hours

CONTRIBUTORY (Secondary)

Signed Thos. D. Norton M. D.

(Coroner) (Address) Curtis Bay Back to Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See Reverse Side for Additional Space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va Date of Burial Nov 19 1927

20 UNDERTAKER Robert Brookseson ADDRESS Calhoun Hollins Sts

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

Spec.–7-17-26—A Co.—200 Bks.

E 27553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 27553

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4100 Greenway St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Greenway

(a) RESIDENCE NO. 4100 Greenway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Frances Davis Greenway

6 DATE OF BIRTH (month, day, and year) Sept 8th 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	77	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired C. P. C.

(b) General nature of industry, business, or establishment in which employed (or employer) Chief Public Accountant C. P. C.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) New York

PARENTS

10 NAME OF FATHER John Henry Greenway

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Kate Hoke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Hilton Harford Co Md

14 Informant Hilton Greenway

(Address) Parkton Md

Filed NOV 18 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Nov 16th 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 9th, 1927, to Nov 16, 1927, that I last saw h~~im~~ alive on Nov 16 1927, and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia.

(duration) 0 yrs. 0 mos. 9 ds.

CONTRIBUTORY (Secondary) Myocarditis Influenza

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. W. Lemmon M. D.

Nov 19 1927 (Address) 132 Int. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Greenmount Cem	Nov 18 1927
20 UNDERTAKER	**ADDRESS**
Henry Jenkins Son Co	Charles & Preston

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27554

CERTIFICATE OF DEATH.

REGISTERED NO. 162 E 27554

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 441 E. 28 ST., 12-50 WARD)

2-FULL NAME Baby Allender

(a) RESIDENCE NO. 441 E. 28 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9d yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of L. J. Allender

6 DATE OF BIRTH (month, day, and year) 11-16-27

7 AGE Years Months Days If LESS than 1 day, 17 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Gone operator~~

(b) General nature of industry, business, or establishment in which employed (or employer) Running Crane

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Norfolk Va Balto. Md

PARENTS

10 NAME OF FATHER L. J. Allender

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk, Va

12 MAIDEN NAME OF MOTHER Dorothy Allender

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Dorothy Allender

(Address) 441 E 28th

Filed NOV 18 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-17 1927

17 I HEREBY CERTIFY, That I attended deceased from 11-16 1927 to 11-17 1927

that I last saw her alive on 11-16- 1927

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage from Mother.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis?

(Signed) C. F. Taylor M. D.

, 19 (Address) 172 W. Va Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hanpden DATE OF BURIAL Nov 18 1927

20 UNDERTAKER A. S. Marshall ADDRESS 359 Fallsway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

268.38 E 27555

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126 E 27555

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST. 13-59 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Smith

(a) RESIDENCE NO. 2402 Druid Hill ave ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Natalie Smith

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	37			

8 OCCUPATION OF DECEASED Stone

(a) Trade, profession or particular kind of work Mason

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Tom Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella ?

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Friends (Address) Johns Hopkins Hospital

15 Filed NOV 18 1927 THAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov 3, 1927, to Nov 16, 1927, that I last saw him alive on Nov 16, 1927, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Sub phrenic Abscess

Generalized fecal Peritonitis

Empyema.

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Intestinal perforation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Raymond Wing. M. D.

11/16, 1927 (Address) Johns Hopkins Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem DATE OF BURIAL Nov 18 1927

UNDERTAKER David T Easton & Son ADDRESS 916

TION is very important See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified.

Spec.–7-17-26–A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 27556

E 27556
1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Providence Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Robert

(a) RESIDENCE NO. 916 Park Ave St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE: Years 33 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) West River Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)
(State or country) West River

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) West River

14 Informant Hattie Roberts
(Address) 916 Park Ave

15 Filed NOV 18 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 19 27

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1927, to Nov 17, 1927, that I last saw him alive on Nov 16 1927 and that death occurred, on the date stated above, at 3 55 P.M.

The CAUSE OF DEATH* was as follows:

1 Myocarditis & Nephritis

(duration) Unknown

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Signs

(Signed) John G. Jamison M. D.

19 (Address) Providence Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenville S. C. Date of Burial Nov 18 1927

20 UNDERTAKER Dennis Eastern ADDRESS 916 Park Ave

IMPORTANT—This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 27557 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 27557

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2223 Druid Hill Av ST., 14-59 WARD)

2-FULL NAME Gladys Duncan

(a) RESIDENCE NO. 2223 Druid Hill Av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 16. 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	33	11	1.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer) Home Maid

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert J. Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Addie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Pleasant E. Duncan

(Address) 2220 Druid Hill Av

15 Filed NOV 18 1927

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Novbr 17 1927

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1927, to Novbr 17th, 1927, that I last saw h e alive on Nov 16th, 1927, and that death occurred, on the date stated above, at 1255 pm

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(duration) — yrs. Obs mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination & Symptoms

(Signed) Edward E. Mackenzie, M. D.

Nov 17, 1927 (Address) 1339 N Howard av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Nov 17 1927

20 UNDERTAKER Daniel Caton — ADDRESS 916 Mc

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 27558 HEALTH DEPARTMENT—CITY OF BALTIMORE. E 27558

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 N. Central ave ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles S. Stevens

(a) RESIDENCE NO. 420 N. Central ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Geo. W. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Henrietta Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Marion Crapper

(Address) 420 N. Central ave

15 FILED NOV 18 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1927, to Nov 16, 1927, that I last saw him alive on Nov. 16, 1927 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Oedema of the lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? examination of urine

(Signed) Robert J. Green, M. D.

11-17 1927 (Address) 120 Haugwout St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL Nov 17 1927

20 UNDERTAKER David Easton ADDRESS 716 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 27559

129 E 27559

REGISTERED NO.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. 5-8 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Montague.

(a) RESIDENCE NO. 1015 McCulloughs St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Hattie Montague

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE: Years 40 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER S. Montague

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliz. Parker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant

(Address) Emergency Hospital

15 Filed NOV 18 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1927, to Nov. 16, 1927

that I last saw him alive on Nov. 14, 1927

and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with

hypostatic pneumonia

(duration) 2 weeks yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) [illegible] M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. Date of Burial Nov 17 1927

20 UNDERTAKER Daniel Easton ADDRESS 916 Fa ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 27560 HEALTH DEPARTMENT—CITY OF BALTIMORE E 27560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 2576 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Johnson

(a) RESIDENCE NO. 0 St. & 2nd Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 0440

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Records.

15 Filed NOV 18 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11/1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1927, to Nov. 11, 1927, that I last saw h live on Nov. 11, 1927 and that death occurred, on the date stated above, at 7:10 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & Lab.

(Signed) C. Hampson Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct. DATE OF BURIAL Nov 11 1927

UNDERTAKER E. A. Kahn & Son ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 27561

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27561

CERTIFICATE OF DEATH.

181-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 N. Gilmor St., 16-27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. H. Banks

(a) RESIDENCE NO. 113 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Jones Banks

6 DATE OF BIRTH (month, day, and year) 1-24-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Coal & Ice

(c) Name of employer American Ice Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown.

14 Informant Marie Thompson, Daughter

(Address) 2121 Division St

15 Filed NOV 18 1927 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15-1927

17 I HEREBY CERTIFY, That I attended deceased from 10-3-, 1927, to 11-15-, 1927, that I last saw him alive on 11-10-, 1927, and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Chronic Valvular Heart (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) about (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) Thos C Page M.D.

, 19 (Address) 516 N. Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Nov 18 1927

DATE OF BURIAL

20 UNDERTAKER Virginia A Brooks

ADDRESS 1460 Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 27562

HEALTH DEPARTMENT—CITY OF BALTIMORE

94-00 E 27562

CERTIFICATE OF DEATH

REGISTERED NO. 12-50

1-PLACE OF DEATH

City of BALTIMORE: (No. 2434 Barclay St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R C Gorrell

(a) RESIDENCE NO. 2434 Barclay St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Gorrell

6 DATE OF BIRTH (month, day, and year) May 6 1853

7 AGE	Years	Months	Days
	74	6	10

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Book Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co (State or country) md

PARENTS

10 NAME OF FATHER Louis Gorrell

11 BIRTHPLACE OF FATHER (City or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Cordelia Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant Maude B Moller

(Address) 2434 Barclay St

15 Filed NOV 18 1927 16 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-16 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 12th, 1927, to Nov 16, 1927, that I last saw him alive on Nov 16, 1927, and that death occurred, on the date stated above, at 11:55 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) G. L. Benton, M. D.

"16, 1927 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aberdeen Md via Penn. R R — Date of Burial Nov 18 1927

20 UNDERTAKER John F. Deany — ADDRESS 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27563

CERTIFICATE OF DEATH

1927 E 27563

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) New Hospital (Ward) 30

2-FULL NAME Leo. A Lyons

(a) RESIDENCE NO. Martinsburg W Va St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Wh.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 35 Months Days

If LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Martinsburg

(State or country) W Va

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

PARENTS

14 Informant (Address) University Hos Reeds

Date NOV 18 1927 C. HAMPSON JONES, M. D.

Per ___ Registrar

CORONER'S CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) Nov 18, 1927

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

Inquiry

Lus

person and from the evidence obtained by said (Autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Homicide

Fracture of Skull

Shock

Duration: yrs. mos. 24 hrs

CONTRIBUTORY (secondary) (Duration: yrs. mos.)

Nov 18 (Signed) Geo Lenton Blades M. D.

27 (Address) 143 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Martinsburg W Va Date of Burial: Nov 18th 1927

20 UNDERTAKER: Geo L Smith

ADDRESS: 1532 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27564

CERTIFICATE OF DEATH.

178 E 27564

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Caroline Hosp St. 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Henry Miller

(a) RESIDENCE NO. 3613 Sycamore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie

6 DATE OF BIRTH (month, day, and year) Dec 8. 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
35	36	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nov. 15

(State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER Charles Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Philadelphia Pa.

12 MAIDEN NAME OF MOTHER Ella Murray

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Philadelphia Pa

14 Informant Jennie Miller

(Address) 3613 Sycamore St

Registered NOV 18 1927 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said jury find that said deceased came to his death

(Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cause Unknown

(duration) yrs. mos. ds.

(Signed) Jas. T. Hennessy M. D.

(Coroner)

Nov. 15, 1927 Address) 2572 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3613 Sycamore Ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery Date of Burial Nov 18 1927

20 UNDERTAKER Jos. Thompson & Son ADDRESS 1127 E. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27565

CERTIFICATE OF DEATH.

165 E 27565

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hosp. St. 13-57 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert A. Curran

(a) RESIDENCE NO. 3614 Falls Rd. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state CAUSE

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen M. Curran

6 DATE OF BIRTH (month, day, and year) Feb. 1, 1896

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31 Yrs.	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pa.

PARENTS

10 NAME OF FATHER Patrick J. Curran

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Clancy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant (Address) Mr. Patrick J. Curran New Martinsville, W. Va.

NOV 18 1927 HAMPSON JONES, M. D.

Per RMC Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 7

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, and made inquiry thereon and from the evidence obtained by me

find that said deceased came to ... death on the day stated above. (Autopsy or Inquiry.)

Inquest held Nov 18 to say Inquest adjourned to Nov 25

The CAUSE OF DEATH* was as follows:

Cyanide Potash Poisoning

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

Coroner

Nov 18 1927 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden Date of Burial Nov 18 1927

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Falls Road

Cor.—12-9-25—A Co.—200 Bks.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27566
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

66

E 27566
REGISTERED NUMBER

City of BALTIMORE: (No. Franklin Square Hosp. St. 13-51 Ward)

2-FULL NAME Helen M. Curran

(a) RESIDENCE NO. 3614 Falls Rd. St. Ward
(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Albert A. Curran

6 DATE OF BIRTH (month, day, and year)
July 29, 1898

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	29 Yrs.	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Philadelphia

PARENTS

10 NAME OF FATHER Jos. J. Moclosky

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Catherine Norton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Albert A. Curran
(Address) 3614 Falls Rd.

NOV 18 1927 HAMPSON JONES, M. D.
Filed Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 12, 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above at [illegible] (Inquest or autopsy.)
Inquiring & Autopsy
Inquest & Autopsy
from the evidence obtained at [illegible] (Inquest or autopsy.)
and that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Thos. B. Horton M. D.
(Certifier)
Nov 18 1927 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden Date of Burial Nov 18 1927

20 UNDERTAKER Chenowith & Son ADDRESS 3615 Chestnut Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27567

CERTIFICATE OF DEATH.

E 27567

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1926 Walbrook Ave St. 15-21 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis John Meagher

(a) RESIDENCE NO. 1926 Walbrook Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	79	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Do Not Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do Not Know.

14 Informant Mrs. Joseph Keane. (Address) 1926 Walbrook Ave.

15 [illegible]

NOV 18 1927

HAMPSON JONES, M. B.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1927, to Nov 16, 1927, that I last saw h[illegible] alive on Nov 16, 1927, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma Gland of Breast (Regarded) duration yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Metastasis duration yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Sept 18/27

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. F. Clegett M. D.

Nov 11, 1927 (Address) 150 4th McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11-17-27
20 UNDERTAKER	ADDRESS
Martin Fahey Sons.	1820 North Ave.

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Louise

E 27568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 143-001

E 27568

1-PLACE OF DEATH JOHNS HOPKINS HOSP.

CITY OF BALTIMORE: (No. ..... ST., 1-9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Lulus

(a) RESIDENCE NO. Kempton West ST., Va. WARD Non Resident

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joe Lulus

6 DATE OF BIRTH (month, day, and year) 12-31-07

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	19 20	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER Stanley Pifel

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Elsie Johnson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Lithuania

14 Informant Husband (Address) JOHNS HOPKINS HOSP.

15 Filed NOV 18 1927 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1927, to Nov 16, 1927, that I last saw h[illegible] alive on Nov 16, 1927, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Chorea

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Kempton, Md

Did an operation precede death? Yes Date of 11-16-27

Was there an autopsy? No. Kempton Abortion

What test confirmed diagnosis?

(Signed) C H Peckham, M. D.

11-17, 1927 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
THOMAS WEST VIRGINIA	Nov. 20. 1927

UNDERTAKER John Grebliauckas & Co. ADDRESS 423 S Paca St.

FROM IS very important See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 27569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11 E 27569

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Providence Hosp 6-9 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Wright

(a) RESIDENCE NO. 618 Mullikin St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1908

7 AGE: Years 19 Months 5 Days

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lab.

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town): Sumter S.C.

(State or country) ~~Carolina~~

PARENTS

10 NAME OF FATHER Gordon Wright

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Sumter S.C.

12 MAIDEN NAME OF MOTHER Emma Sayd

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Sumter S.C.

14 Informant (Address) Providence Hospital

15 Filed NOV 18 1927, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1927, to Nov 16, 1927, that I last saw h[illegible] alive on Nov 16, 1927, and that death occurred, on the date stated above, at 10.30a m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/15/27

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Bernard Hamm, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sumter S.C. Date of Burial Nov 19 1927

20 UNDERTAKER: Edward Bryan ADDRESS 1634 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 27570

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 27570

CERTIFICATE OF DEATH.

1855

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) MW Hosp St. H-No Ward)

2-FULL NAME Geo W. A. Smallwood.

(a) RESIDENCE NO. 730 Bocher St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Dec 12 1875

7 AGE

Years	Months	Days	IF LESS than 1 day hrs. or min.
52	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): West River

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Geo Wallmallwood

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: S Peters

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant

(Address): L Smallwood 1006 Brandy ave

Filed NOV 18 1927 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Nov 16 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry)

thereon and from the evidence obtained by said (Coroner, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Fracture of Skull

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

Signed (Coroner) M. D.

18 (Address) 143 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn

Date of Burial: Nov. 19 1927

20 UNDERTAKER: Joseph A Lively.

ADDRESS: 409 Mount St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

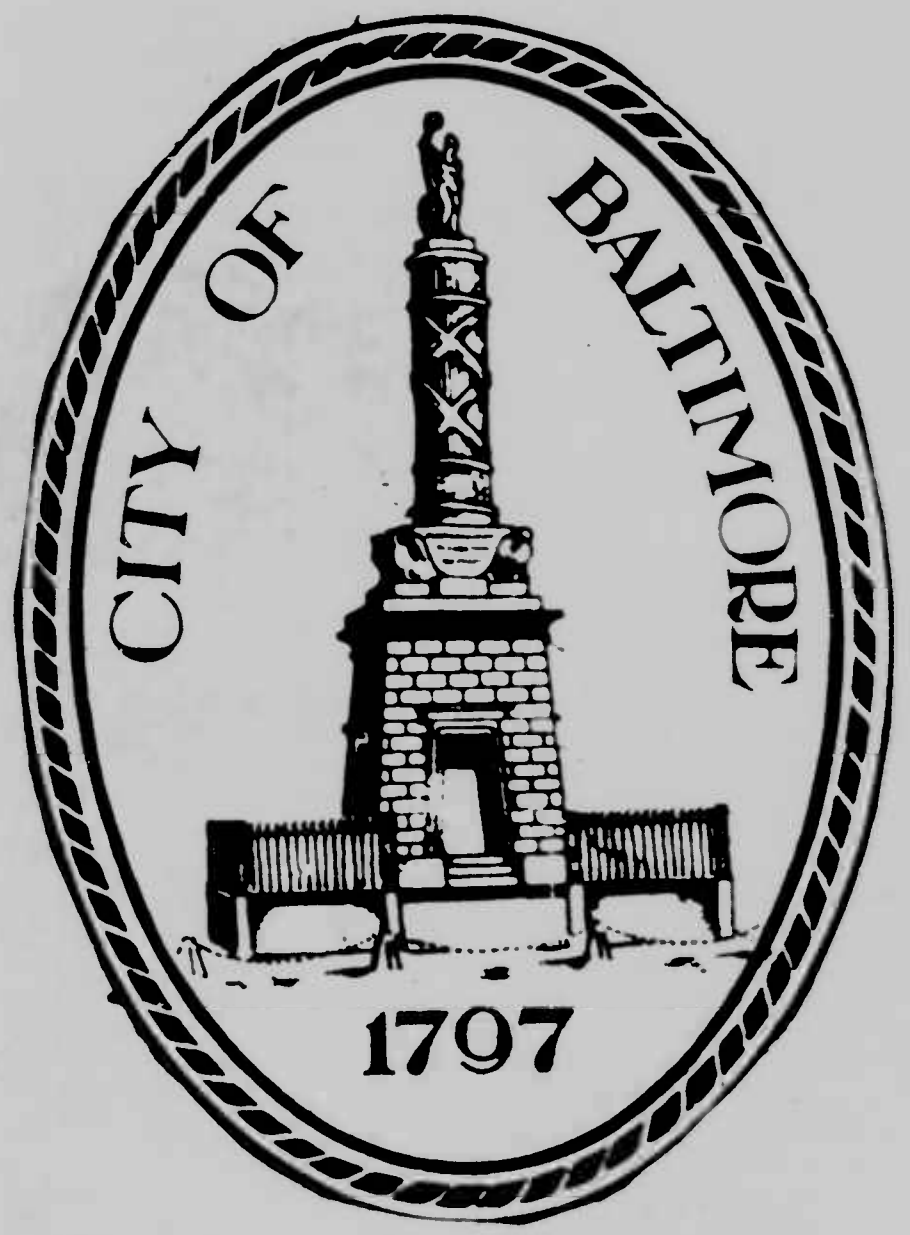
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 21st DAY Apr
OF 1965 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH #E 24076 July 19, 1927 AND
ENDING WITH #E-27570- Nov. 18, 1927 ARE AC-
CURATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: D McFaul



END OF REEL